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The Hospital, the Family Doctor and the Patient

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New York City

THE family doctor has been patted on the back so frequently of late that that part of his anatomy must be getting rather sore. There are two things that he can do about it: he can continue to subject himself to these well meant attentions and can treat the painful parts in his own way (nowadays no one questions his competency to cure so simple an ailment), or, resorting to the strategy of preventive medicine, he can save himself from further injury by keeping his admirers at arm's length while he proceeds to ascertain just what it is that they wish to do for him or to him.

The issue concerning the place of the family doctor in present and future practice has been clearly drawn in the discussions that have recently taken place. In the center of the stage stands the family doctor, conservator of the highly prized personal relationship between patient and physician—the object of universal homage, but homage sometimes offered, I fear, in a manner not altogether sincere, for I have observed no marked decrease in the number of waiting patients in the anteroom of the family doctor's friend the specialist, or any unwillingness on the part of the specialist to receive them.

At the family doctor's right hand stand those who in the name of efficiency and economy urge his absorption into the organized fabric of a glorified hospital or an octopuslike medical center, in accordance with a plan which assigns to these splendidly equipped units "responsibility for furnishing complete medical service for the local population or some section thereof," and which promises to the family doctor as a member of the responsible organization a valuable share in the "control, management and operation of the costly accessories of medicine, a division of expense for these accessories, greater efficiency, greater opportunities for work, more ease in postgraduate study and in vacations, more cooperation from his friends and neighbors, more education from constant association with others." This is certainly an enticing offer, yet its intended recipient hesitates to accept it, for at his left stand a host of warning counselors who with many manifestations of alarm urge him to resist to the bitter end the creation, the continuance or the expansion of any and every form of organization that might deprive him of any part of his traditional liberty or lessen the intimacy of his professional relation to his patient.

In the controversial literature of the day, one does not always find a confrontation of principles as simple as this. In any formal plan for the extension of group practice or the widening of the sphere of the hospital, a loophole is usually left through which a small fraction of independent private practice may conceivably escape and survive. Similarly, even the more rigorous champions of unhampered individual practice concede the advantages of group practice in a limited area, which they reserve for the activities of specialists. Notwithstanding these slight concessions, the fact remains that the family doctor is being urged in opposite directions by two antagonistic schools of thought, each of which regards itself as the bearer of the only true doctrine of medical salvation.

Family Doctor Dislikes Health Center Plan

Thus we find that the comprehensive, inclusive, communitywide organization of all varieties of necessary medical service, the advantages of which to patient and doctor are so eloquently pleaded by the Majority of the Committee on the Costs of Medical Care, is characterized by the Minority of that committee as "far-fetched and visionary." Among the Minority's objections to the health center plan which the Majority so warmly espouses are that "it would establish a medical hierarchy in every community, to dictate who might practice medicine there; it would be impossible to prevent competition, among the many such centers necessary, to assign patients to the various centers"; while "the continuous personal relationship of physician and patient would be difficult if not impossible under such conditions."

The advocates of organized group practice are asked by the Minority to bear in mind that "the majority of illnesses and injuries (about 85 per cent) are of such a nature that they can be treated efficiently by any able general practitioner with very simple equipment; in fact, the general practitioner does not need elaborate apparatus of any kind"; that "the general practitioner is quite capable of taking over many of the procedures now assumed by specialists and should do so," and that the general practitioner "must be equipped to render a good medical service to the families in which he becomes the trusted medical adviser."

Although the report of the Majority of the Committee on the Costs of Medical Care embodies the carefully stated conclusions of a large group of distinguished and public-spirited men, and is based upon volumes of evidence which should be consulted by anyone who wishes to acquaint himself with all of the facts of current medical practice, the Minority's objections to the health center plan cannot be lightly dismissed. It is becoming increas-

ingly evident that the health center plan is not a popular one; that it does not make the practitioner's mouth water, notwithstanding his natural craving for sustenance and the extremely meager fare upon which he now subsists. However conscientiously prepared, however skillfully treated with the appetizing condiments and the tantalizing sauces of steady income and improved professional opportunities the proffered meal may be, the instinctive disposition of the family doctor is to reject it.

If now, we turn to the dissenting or Minority report, we find that the recommendation which is most characteristic of the Minority's attitude toward the problem of general practice is "that united attempts must be made to restore the general practitioner to the central place in medical practice." A statement of that kind doesn't mean much unless it is backed up by a program, and the principal affirmative means proposed by the Minority for the accomplishment of its purpose is "the preparation of the student in the medical school the better to fill the place which he (the general practitioner) has always occupied." This recommendation is advanced in face of the fact that much of the available evidence indicates that medical practice is steadily moving beyond the general practitioner's reach as a result of powerful social forces which a mere change of undergraduate educational emphasis can hardly be expected to control. The diet offered to the family doctor by the Minority strikes me as a meager diet indeed—a mere bread and water ration at best, which tends to diminish in quantity and to deteriorate in quality wherever industrial or contract practice, group clinics, university medical centers, public hospitals, pay clinics or free dispensaries flourish.

Too Heavy a Burden Placed on the Doctor

A vital element in the situation is the actual growth of free medical service. The Minority believes, and in this belief I heartily concur, that in the medical care of the indigent, society has thrown too great a burden on the doctor, and few will be disposed to criticize its recommendation "that the government care of the indigent be expanded with the ultimate aim of relieving the medical profession," or to question the statement that through the adoption of this policy "the income of physicians would be increased." It is certainly true that if the government took over all the free work that doctors now carry on privately and in addition provided proper remuneration for the physicians who actually do the medical work of public hospitals and clinics, substantial benefits to the doctors would accrue. But how can a pro-

gram for the further expansion of the government's huge existing medical program be reconciled with the purpose of restoring the family doctor to a central place in the practice of medicine? How does it square with the aim of maintaining or of reestablishing personal relations between physician and patient?

In a rural community, the inhabitants being few and the indigent sick fewer, public responsibility for medical care of the poor might conceivably be discharged by designating an individual doctor to serve as the government's agent, but in towns and cities the volume of such care soon compels resort to the methods of organized practice, and as medical organization advances, the personal relations between doctor and patient fade away.

Two Extremes in Government Medical Care

Extremes of method in government medical care for the indigent are strikingly presented in a village some forty miles from New York City, where I live in the summer, and in the great metropolis itself. When a poor patient is admitted to the modest community hospital in the village, he is assigned to one of the village doctors (all of the members of the county medical society, by the way, have access to the hospital), and the county, through the local poormaster, pays both hospital and doctor's bill. Here we have an instance of government medical care in which the indigent patient receives personal attention which, if the doctor is at all conscientious, does not differ materially from the care customarily bestowed on a private patient.

Now contrast this with public practice in the metropolis, where a patient of the same class would be one of a hundred admitted in a single day to a hospital containing five hundred, a thousand or even two thousand beds; where he would be placed on the service of an experienced visiting physician of respectable reputation, but where, unless the case happened to be one of particular clinical interest, the actual care of the patient would probably be assigned to a youthful resident or intern who might have as many as sixty, eighty or even a hundred patients in his charge.

If we turn from in-patient to out-patient service, we find that in New York City, Boston, Philadelphia, Buffalo, Cleveland, Chicago, Minneapolis, San Francisco, Los Angeles and elsewhere, public clinics vie with university medical centers in the elaborate organization of dispensary staffs whose treatment of ambulatory patients is of necessity conducted on a quantity basis. What vestige of personal relationship remains, in a huge public clinic, between the individual doctor and his innumerable patients? The expanding activity of

public general hospitals and clinics, which is almost universally coupled with unpaid professional service and which involves a corresponding shrinkage in paid private practice, has not been to the advantage of the family doctor. As a rule, the doctor takes his punishment without a murmur, for unselfishness is the very essence of the profession to which he has dedicated his life and of which he strives to be a worthy member. If physicians now and then protest that they will no longer submit to exploitation, who can blame them? But the payment of medical salaries by huge public hospitals and clinics which are constantly adding to the volume of their work seems an unpromising way of avoiding the dangers of group or mass practice or of preventing nonmedical participation in the control and direction of medical practice.

Although a substantial majority of the hospital beds of the country are already government supported, so far as I know it has not been suggested by anyone that any important part of this service be discontinued (a possible exception is the suggestion that some of the services which a too generous government has been offering to veterans for nonservice connected disabilities be abolished). And in any appraisal of the present position and future prospects of private medical practice, not only hospital service *per se*, but free dispensary service must be taken into account.

An Economic Threat to Medical Profession

There were 150 clinics in the country in 1900, 2,300 in 1910, nearly 4,000 in 1920, more than 6,000 in 1930. In 1931, 3,456 out of 6,571 clinics in the United States reported over thirty million visits; for all of the clinics in the country, including those not reporting, the number of visits in 1931 is estimated at forty million. Complete figures for 1932 are not yet available, but a sharp increase in attendance at clinics maintained by the public authorities is reported in nearly every part of the country. A municipal hospital in the Middle West reports a growth in its daily out-patient service from 250 in 1931 to 800 in 1932. The out-patient department of a great municipal hospital in New England reports that daily visits averaged 900 in 1931 and nearly 1,500 in 1932. New York City experienced in 1931 an increase in dispensary attendance of nearly two million visits—equivalent to the entire growth of such attendance during the eight preceding years.

It is true that these figures in part reflect the industrial depression, but who knows when the normal earning power of the working classes will be restored or whether the restoration of prosperity, when it comes, will be followed by a corresponding restitution of private medical practice?

The indefinite expansion of free public medical service on existing lines threatens the economic existence of a large part of the medical profession, and presents a problem that demands serious consideration.

Compulsory health insurance has been suggested as a means of dealing with this problem, but compulsory health insurance offers no bed of roses to the conscientious doctor, to the insured patient or to any social-minded government that undertakes to administer the system. The thoughtful observer of the medical aspects of our workmen's compensation laws sees little to encourage him to advocate the adoption of a new and even more complicated system of governmentally supervised medical care which strews temptations in the path of doctor, patient and public official.

Questions the Medical Profession Must Answer

However, the basic idea of health insurance, namely, the principle of distributing the cost of medical care over groups of the population and over long periods of time, is perfectly sound, and in compulsory health insurance of the English pattern (inadequate and faulty as that pattern undoubtedly is) the general practitioner, freely chosen by his patient from a numerous panel of neighborhood doctors, appears to occupy a position in which he is closer to his patient than he is likely to be if he becomes a salaried employee of the state with a fixed institutional assignment in the expanded system of public hospitals and dispensaries toward which we in this country are heading today. How long will it be, I wonder, before the number of low salaried working people receiving free medical service in our public institutions is proportionately equal to the number of English workers that come under the operation of the British compulsory health insurance act?

The field of organized medical service which the state is destined to occupy in our country embraces, as I see it, not merely the care of the penniless class but large groups of low salaried workers, many only intermittently employed, whose means are conceded by everyone to be inadequate for the unaided purchase of proper medical care. If state aid continues to be extended in increasing volume to this group and if it is modified so as to cover the cost of the services of physicians, the area of contract medical practice will be enormously expanded. It is therefore essential that in the current discussion of medical economics, the problem of the care of the "indigent" by the government be placed in the conspicuous position to which its importance entitles it.

In the growing sphere of medical practice under government auspices, what is to be the precise

rôle, what the public and private relations of the family doctor? How will he fare? What method of medical payment is most likely to assure reasonable remuneration, the best service to the sick, the largest freedom of opportunity to the doctor and the widest range of choice of physician, as well as that great desideratum, the professional control of medical activities? These are questions that the medical profession must be prepared to answer in the near future.

As long as the present social economic order endures, we shall have to deal with two great social branches of medical practice. The first of these, practice under government auspices, has been mentioned, but far from adequately described; not even a classified directory of this service, extending from hospitals for the mentally ill and tuberculosis sanatoriums at one end to prenatal clinics at the other, can be presented within the limits of this paper. There remains the diminished but still important field of private practice. What are the present opportunities of the general practitioner in this second field? How can these opportunities be extended and improved? Should the public be content with the present quality of the family doctor's service? To this latter question, conflicting answers have been given.

The distinguished editor of the *Journal of the American Medical Association*, a firm believer in the function of the family doctor, recently declared that "the person of any class, if he consults his family doctor is likely to have more than an even chance for good medical care without exploitation." Doctor Fishbein's eloquence and effectiveness as an advocate are well known, but in this instance an impartial judge would probably find that he had understated his client's case. If "more than an even chance" of getting good medical care "without exploitation" were all that the family doctor's patient could hope for, the sociologists who have become interested in medical affairs could scarcely be blamed for training their critical guns directly on the sacred citadel of medical practice.

No Group Should Be Excluded

I have already referred to the recommendation of the Majority of the Committee on the Costs of Medical Care that hospitals and medical centers extend their services into patients' homes, thus providing "complete medical care for the local population or some section thereof." Now, if group practice possesses all the virtues that are attributed to it, it is manifestly desirable that the section of the population which is excluded from its benefits should be as small as possible and preferably that there be no excluded group what-

ever, and one may reasonably assume that this is what the committee would like to see, although it is careful to explain that anyone may remain outside of the system who chooses to do so.

The arguments for group practice—now fairly familiar to both layman and physician—are based upon two broad grounds, economy and efficiency. In my opinion, cooperative medical practice derives its special sanction not so much from its economic advantages as from the complex character of modern medicine and the number and limited application of its specialized technical skills, which make it indispensable at times, but not always. The Minority of the Committee on the Costs of Medical Care, opposed as it is to the extension of group and clinic practice, nevertheless concedes the logic of this type of organization, but would like to see group organizations restricted in number and scope, and offers as an advantageous substitute "medical care furnished by the individual physician, with the general practitioner in the central place." It asks that groups and clinics be "organized only where the nature of the situation and character of the personnel render such organization a natural development."

A Constant and Universal Need

I confess that I am puzzled by the wording of this recommendation, for does not the "nature of the situation" everywhere render group or cooperative practice a natural development? Wherever there is a patient, a complex as well as a simple clinical problem may arise and a union of medical forces may be needed to ensure satisfactory treatment. Medicine being the manysided science and art that it is today, group practice is not a local or intermittent but a constant and universal need.

"Groups of specialists," the Minority declares, "as distinctive organizations are very valuable for diagnosing or treating difficult or complicated cases." Is not "groups of specialists" a poorly chosen phrase? The ideal medical group is not a group of specialists but a group that includes both general practitioner and specialists. It would be nothing less than a misfortune for "groups of specialists" to form "distinctive organizations" with the general practitioner left out. This is not a mere quibble: the term employed by the Minority is not only technically incorrect but it is employed in such a way as to summon before the mind the picture of an organization that is outside of and even opposed to the general practitioner, possessing functions apart from general practice. One ought rather to think of specialists as a group complementary to the family doctor; but even this friendlier term has an unsatisfactory connotation, for properly constituted medical groups, including

specialists, are of the very essence of general practice, bone of its bone, flesh of its flesh.

Again I quote from the Minority report: "for 85 per cent of illnesses which make up the family doctor's practice, better service can be given by the individual doctor in his own office than in the clinic." This statement makes it clear that patients differ in their diseases but it fails to remind us that doctors differ in ability, and in so doing it slurs over an important fact. It may be quite true that Doctor X can stand on his own feet with respect to 85 per cent of his cases and needs support only in connection with the remaining 15 per cent; but Doctor Y might do better by his patients if he called in a consultant in 20 per cent of his cases; while Doctor Z would be guilty of poor judgment or of bad faith if he did not admit his lack of ability to deal unassisted with even a larger proportion of his patients. It is impossible to devise any system which will make family doctors equally efficient, but it may be possible to promote the maintenance of sound professional standards by creating the most favorable conditions of practice.

In the conditioning of medical practice, the practitioner's early medical training is in point of time the first potent influence. Since the Majority and Minority agree that this training can be improved, I am content to leave it to them jointly to settle the matter with the medical schools. Let us assume, then, that the content and method of undergraduate instruction are still an unfinished chapter and that further progress can be made in that direction. In all probability the actual treatment of the sick is influenced far more by habits formed after graduation than by the knowledge the practitioner acquires during his undergraduate days. This, at any rate, is my own belief, and hence I say that the key to efficient medical practice today is in the hands of the hospitals, that it is the hospital that chiefly determines the plane upon which, in a given community, medicine shall be practiced.

Family Doctor Needs a Hospital Connection

Nor is the power of the hospital to influence the standards of local medical practice confined to practice within its walls. Given two practitioners of equal talent and like preliminary education, the first associated with a worthy hospital, the second lacking such a connection, the one who enjoys constant contact with a progressive clinical group will soon outshine the other. In the interest of the quality of his service alone, quite apart from any considerations of an economic character, the general practitioner requires a hospital connection. For the family doctor, the hospital holds a whole bag of useful tricks. Its daily gossip on clinical

subjects keeps him alert, its rare cases widen his horizon, its laboratory facilities are a potent aid in diagnosis, its clinical conferences are a running commentary on the virtues and the limitations of modern practice. All patients do not need hospital or group service, but it is the family doctor who must select the patient who should be given its benefits, and if the family doctor has no connection with a hospital or clinic organization, he will fully understand neither the power nor the decided limitations of group practice. Even if the doctor's judgment is sound, he will be more reluctant to refer his patient to a hospital or diagnostic clinic with which he has no connection than to one with which he is associated and to which he can turn with the knowledge that its staff will loyally collaborate with him and will make no attempt to supplant him.

The physician who enjoys a proper institutional association avoids the danger of becoming careless and superficial in his clinical methods. With the whole range of clinical and laboratory medicine spread out before him, he acquires self-confidence in that part of the field which he can personally manage, and readily turns to others for help where his own equipment is inadequate, knowing that he can do so without losing contact with his patient. Nothing is more indispensable to the success of any effort to restore the general practitioner to a central place in medical practice than the creation of right relations between the family doctor and the hospital. Recognition of the need of a hospital connection for every practitioner should be a controlling factor in all community hospital organization, for the practitioner cannot do his job competently unless he enjoys the advantages of a healthy and stimulating professional environment. I should like to point out here that the association of family doctor and hospital which I am discussing is a free association which would not deprive the family doctor of his independence, in which respect it differs from the unified service of the closely knit organization envisaged in the Majority report as I understand it.

A Fair Settlement Must Be Made

Notwithstanding the steady encroachments of public medicine—encroachments that are likely to be carried far beyond their present limits unless the cost of medical care for patients of small income is more evenly distributed under some plan of periodic payment in which the medical profession will consent to participate—there remains a considerable volume of individual medical practice for the continuance of which there is much to be said. Physicians will not give up any part of this practice if they can manage to retain it, but eco-

nomie pressure has already driven a wedge between the family doctor and an important fraction of his patients, and this pressure shows no signs of relaxing. As more and more patients are cut off from their family doctors, they are taken over and assimilated by the hospitals and clinics of a benevolent government and its voluntary allies.

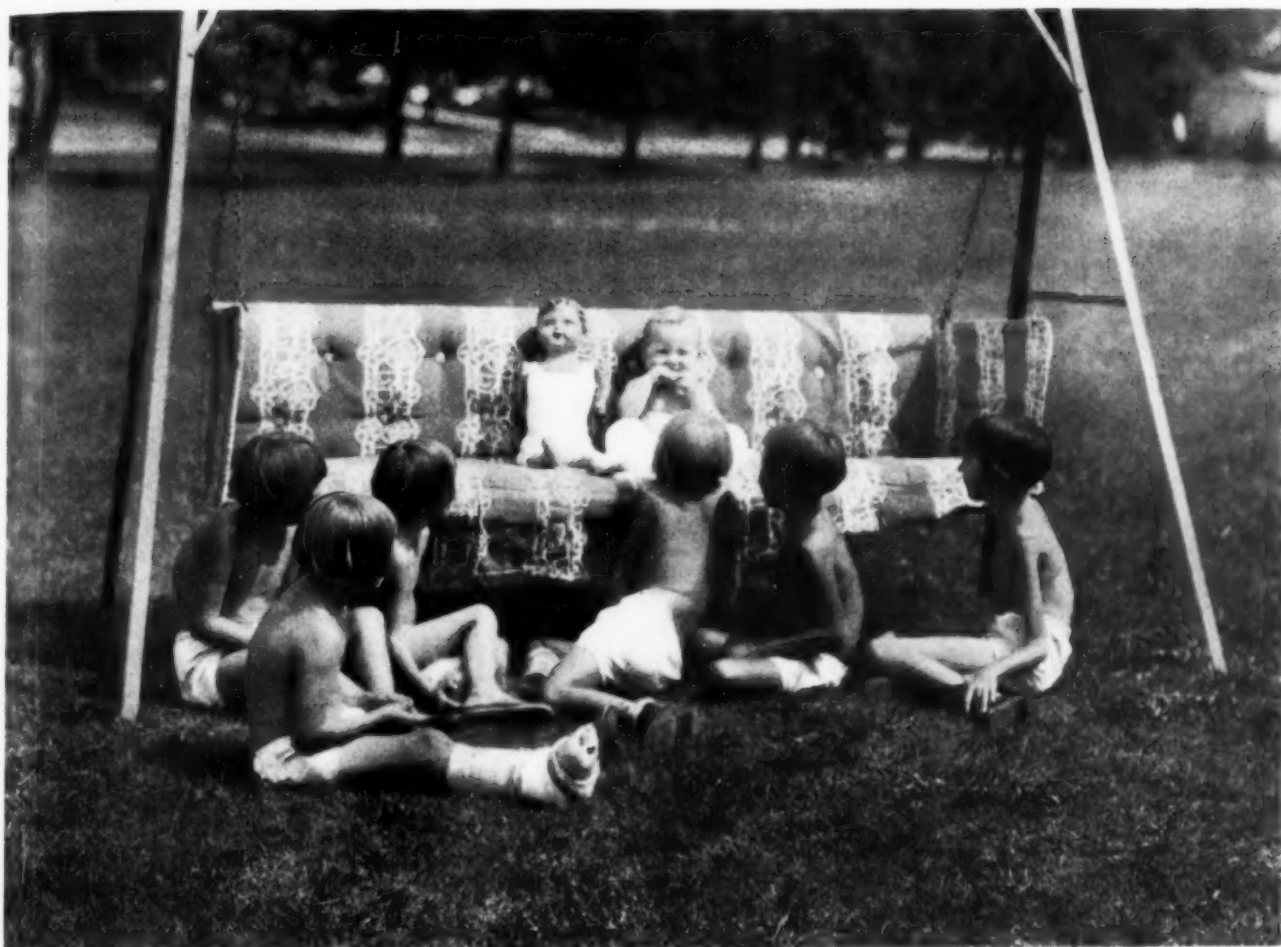
Of the great volume of practice which has already been taken over by public and semipublic institutions, little is likely to be restored to the family doctor; but the terms of future medical participation in this great mass of practice are subject to negotiation, and public interest demands a settlement fair to the medical profession. Otherwise the service will deteriorate and the patients will suffer. Each year, talented college graduates weigh carefully the relative advantages of alternative careers, and the best among them do not always elect medicine.

Hospital and Family Doctor Should Join Hands

Is it possible for hospitals to fulfil their functions and to prosper without taking away the livelihood of the general practitioner? I think it is; but efforts to preserve for the family doctor the practice that remains in his hands will not be aided by fostering antagonism between him and the hospital. In a struggle for existence between individual practice and institutional medicine the latter would have the upper hand, hence the friends of the family doctor should do everything possible to avoid such a struggle and should seek to unite these two complementary units of medical practice in an amicable partnership.

From such a partnership, founded upon the acknowledgment by each partner of the social usefulness and the distinctive qualifications of the other, the family doctor and his patients would derive great benefit. The hospital's participation should be based in part on frank recognition of the public's interest in competent private practice, and should signify the hospital's acceptance of the proper rôle of group medicine in relation to individual private practice, namely to supply whatever needed clinical and laboratory service the family doctor is unable to supply unaided. This is, of course, a special function of the hospital, apart from its normal duty of providing shelter, comfort, convenience, safety and certain economies in medical and nursing care to patients whose illnesses are not complicated, but whose home surroundings are inadequate to their needs.

The suggested cooperation between the hospital and the family doctor in complicated illnesses might be called the associated free practice of medicine. It would take one form in a small community, another in a great city.



Hospital Finds Picnics Are Good Way to Raise Money

By AGNES O'ROKE

Superintendent, Kosair Crippled Children Hospital, Louisville, Ky., and

MRS. JOHN MARSHALL, JR.

Louisville Junior League

FOR the past several years the Kosair Crippled Children Hospital, Louisville, Ky., has given an annual picnic at one of the local amusement parks, and each year the event has resulted in a substantial profit for the hospital. Inasmuch as the hospital's grounds are spacious in themselves, it was decided it would be better to hold the future picnics at the institution instead of at the amusement park. The new plan was placed in operation last year.

The Kentucky Crippled Children's Commission pays the hospital a flat rate for each child admitted, but the institution has found it impossible to operate successfully without financial assistance from

the public; hence, the annual picnics. Since the opening of the hospital in May, 1926, the institution has endeavored to keep the public informed of its activities and work. This is accomplished by means of a carefully planned publicity program. An opportunity is never lost to get a story published in the local newspapers, and the hospital authorities see to it that interesting pictures of the institution are available for publishers. The annual picnic is always preceded by several weeks of intensive publicity work and advertising.

When the decision was reached to hold last year's picnic on the hospital grounds, a committee of three persons was appointed to attend to the de-

tails. The chairman of the committee signed all letters, handled all circular and publicity matters and managed the distribution of the tickets. The other two committeemen served in an advisory capacity.

As a preliminary step blocks of ten tickets, to be sold at ten cents each, were mailed to 12,000 persons in Louisville. The ticket envelopes also contained an attractive folder describing the hospital's work with crippled children and a letter appealing for help. The profit that can be expected from a picnic can generally be estimated by the response made to these letters. We always aim to make expenses on the grounds the day of the picnic. It rained on the day chosen for last year's picnic, and there was the additional expense of postponement.

Income Over \$3,000

The auditor's report shows that the receipts for the picnic, including ticket sales and net income from booths, amounted to \$3,018.57. Disbursements, including such items as printing and mailing circulars and advertising, totalled \$1,494.35, leaving a balance of \$1,524.22.

Since the picnic was given on the hospital

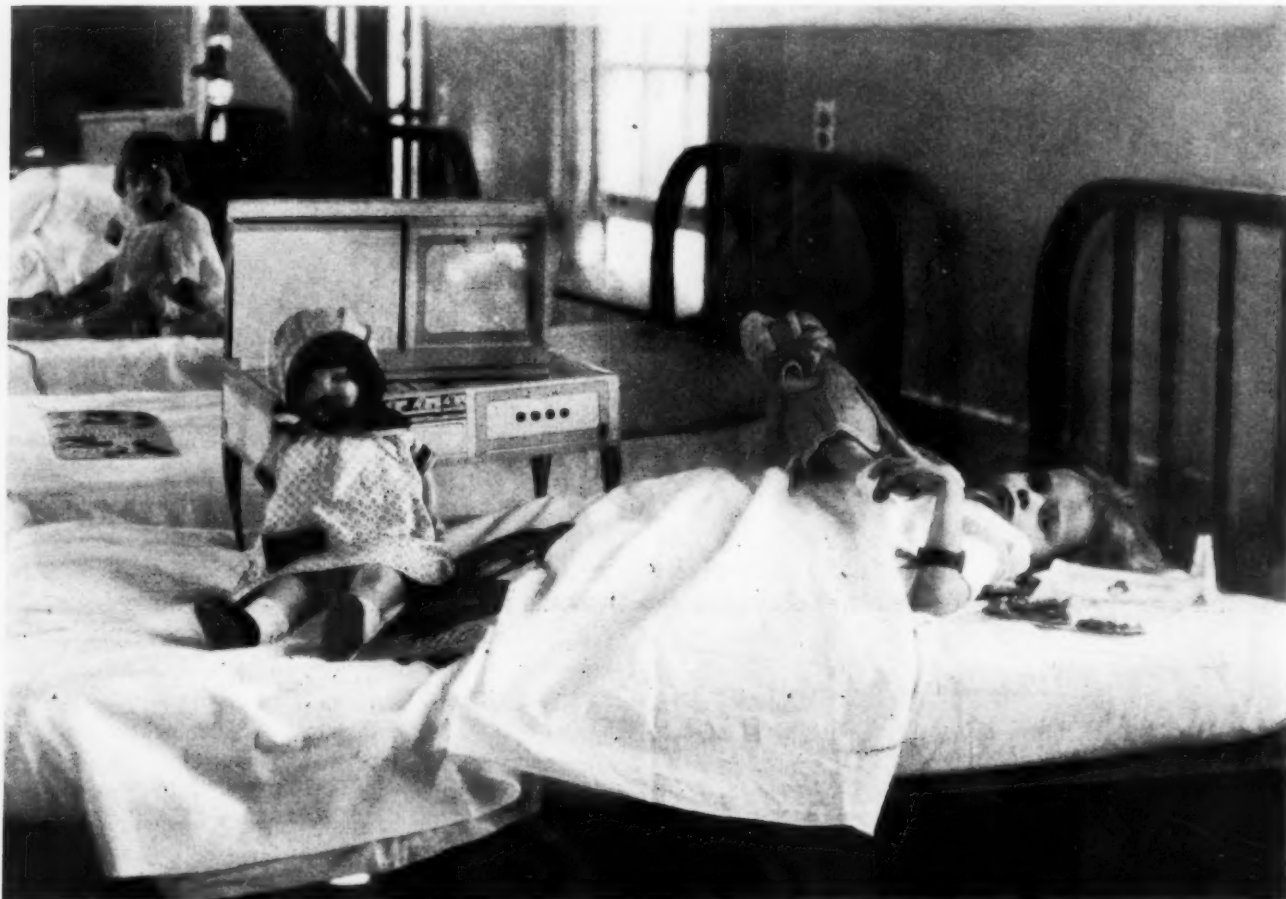
grounds this year for the first time it was necessary to purchase equipment and construct the booths, which was done at a cost of \$1,500.20, leaving a net balance of \$24.02. The booths and equipment, however, are permanent, and can be used each year as the picnic is to be an annual event. In the future our profits should be much larger than this, since it will not be necessary to spend other than a small sum of money for equipment and construction work.

"Depression" Booth a Popular Spot

The picnic was held on a Saturday. It lasted the entire day and until 12 o'clock at night, with an attendance of approximately 2,500. Past experience has shown that contests are the most attractive to the majority of people. Contest prizes such as hams, flowers, electrical appliances and other useful articles were awarded.

The "depression" booth was one of the most popular places on the picnic grounds. Only articles of food were handled at the depression booth, and the cost of the packages was limited to twenty-five to thirty cents each.

All the prizes that were distributed at the picnic were either donated or sold to the hospital at a



Playthings are necessary to make the children happy, and the picnics help make it possible to secure attractive toys for the children in the institution.

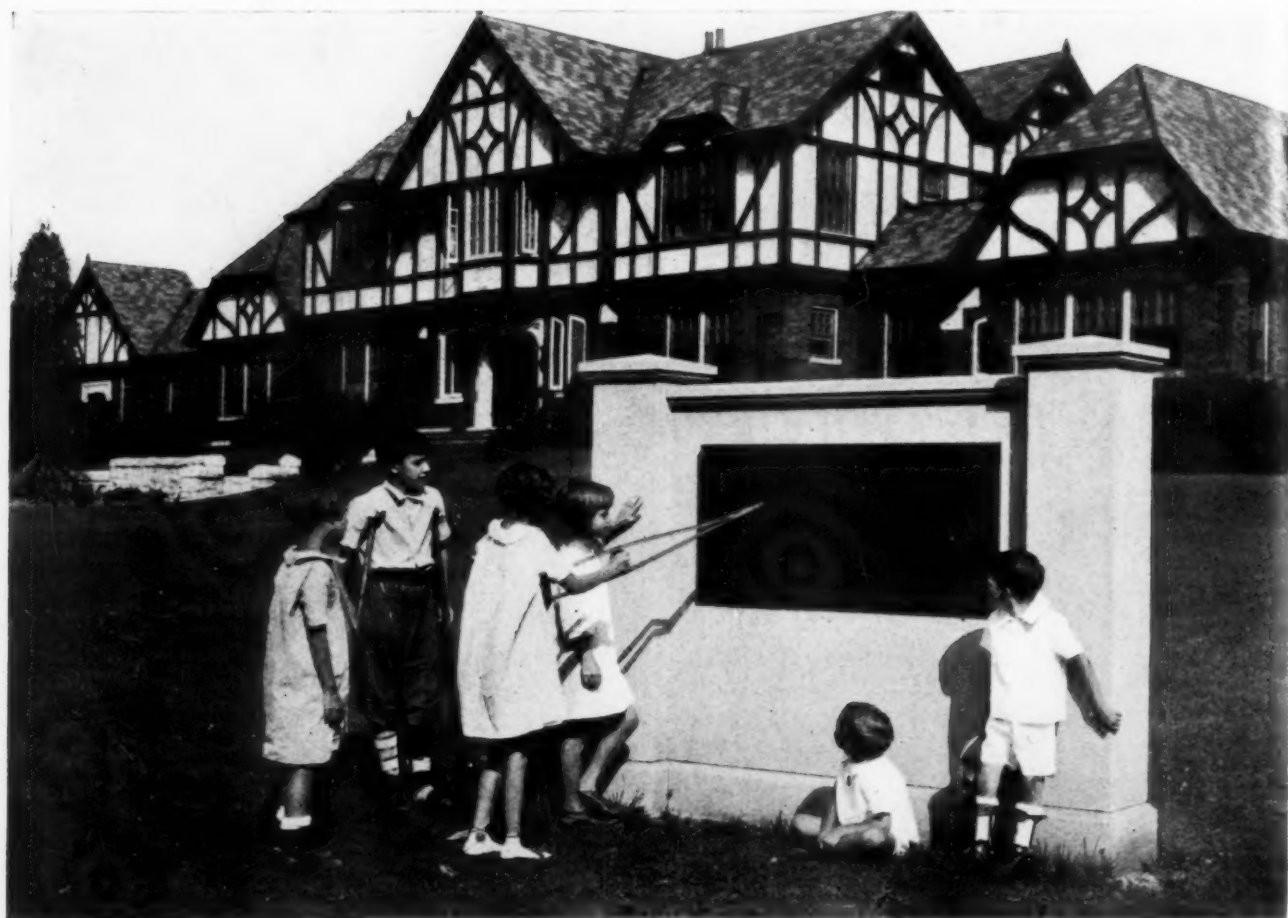


The group of little children shown in the picture at the top of the page are typical of those who benefited from the two picnics described in this article. The lower picture shows the attractive rustic walk leading to the hospital.

below-cost price. The flower booth was conducted by members of the Junior League. The flowers were contributed. A local florist donated the use of his trucks and vases and sent two of his employees to arrange the flowers artistically. Members of the Junior League went about the grounds pinning flowers on the men, and asking them for a small donation. This booth made \$52.99. Soft drinks and sandwiches were sold on the grounds and a good sum was realized from these sales.

A large quantity of tin foil had been donated during the year, but the market price was so low that it was decided to make souvenir ash trays from the tin foil instead of selling it. A number of these





From the exterior the building looks more like a private home than a hospital. The spacious grounds are ideal for picnics.



ash trays were sold at the picnic, bringing in \$53, and since the picnic many more of these souvenirs have been sold.

The hospital's grounds are beautiful and on the night of the picnic they were as light as day. Hundreds of people wandering in and out made an attractive sight. There is ample parking space on the grounds and the police department gave generously of its services in helping people to park their cars and in guarding the money that was collected at the picnic.

The Junior League of Louisville has been active

children under twelve years of age. Box lunches and sandwiches were sold to those persons who did not bring their own. Ice cream, popcorn, soft drinks and milk from the Hurstbourne dairy were also sold. Puppet shows were given and ponies were available for the children to ride. Hams and candies were awarded on Saturday. An orchestra provided by Mrs. Hert played for outdoor dancing on Saturday night. The charge for dancing was \$1 a couple. Lights were strung generously around the lawn, lighting the ice cream, hot dog, candy and other booths. Many couples attended the dance,



Listening to the radio is a favorite amusement for the children. The picnics make possible extra pieces of equipment like this.

in assisting the hospital, and each year it sponsors a money-raising project. Last September the league gave a picnic, but it was somewhat different from the one given by the hospital. The Junior League picnic was held on a Saturday and Sunday, at Hurstbourne, the estate of Mrs. A. T. Hert. Everyone in Kentucky was invited and thousands came to enjoy what was considered the event of the summer. The fête afforded the general public its first opportunity to inspect Hurstbourne, a 1,500-acre estate, long considered one of the show places of Kentucky. The admission price was twenty-five cents for adults and fifteen cents for

which was one of the most successful events.

The feature of Sunday afternoon's program was stunt flying by U. S. Army officers stationed at the local airport, who entertained the crowds with their sky antics. A concert was presented by the Louisville Boys' Band of the Louisville Institute of Music. A number of commercial companies donated refreshments on a concession basis.

Net Profit Over \$2,000

The gate receipts for the two days were \$1,652.15, and our share of the food and refreshment concessions amounted to \$2,273.75, which made a

total of \$3,925.90 cash received. The expenses were \$1,595.40, giving the hospital a net profit of \$2,330.50.

The Junior League considered the picnic a complete success. The local newspapers printed an article and picture each day. The street car company offered a reduced rate to the picnic and the taxicab company donated its services to passengers from the end of the street car line to the farm.

Picnics of the type described are a splendid means for charitable institutions to raise funds. There is a great deal of work in connection with such undertakings, but there is not much expense attached to the work. That projects of this nature may be successful, it is imperative that the public

be kept informed continually of the good work that the institution is doing. Then when a money-raising project is undertaken the public will be in the proper frame of mind to lend its assistance. We have found that the newspapers are always willing to give space to stories and pictures on the institution.

Some hospital superintendents are opposed to picnics and similar activities being given on the institution's property on the ground that the hospital is overrun with visitors and curiosity seekers. At the picnic given on our property, we had signs printed explaining the danger of too many people visiting the children. The message was signed by the hospital's chief of staff and was most effective.

How the Public Looks Upon the Nurse

The public sees the nurse only in her capacity to render adequate service when there is need for nursing care, according to a statement of Mrs. Stanton Freidberg, a member of the Central Council of Nursing Education, Chicago, in a paper read at the Indiana State Nurses' Association meeting. She stated further that the public is uninformed and indifferent concerning the problems that enter into the education of the nurse, just as it is equally ignorant concerning the other professions.

"It knows nothing about the system of which the nurse is a product, it cares nothing about her future. But, and this I say with an emphasized 'but,' somewhere, somehow, we, the group represented here, expect this same public to supply the funds which will bring about a far better system of nursing education than that which we have today.

"Sixteen years ago Dr. Richard Cabot said 'It seems strange that people have not generally and generously realized the need of endowments for this branch of higher education as for every other. No one any longer supposes that a medical school can be both reputable and self-supporting. To maintain proper standards it must be and always is endowed. Tuition fees never have supported a good medical school nor will the nurses' fee (paid in labor) ever suffice to provide proper training for nurses in hospitals.'

"Since Dr. Cabot stated this opinion three schools have been endowed, Yale University, Western Reserve University and Vanderbilt University. The remaining schools are struggling along under the antiquated system comparable only to the guild and apprentice system of the Middle Ages.

Public Should Be Told of Difficulties

"The public resents the fact that some good hospitals do not always produce good nurses. In fact, it does not even recognize the difference between a good hospital and a poor one insofar as its school is concerned. The average citizen has no understanding of the problem that confronts the superintendent of a school when she must accept students primarily to get the hospital work done. Nevertheless, it is this same public that furnishes the endowments for our hospitals and to which we look for endowments for our schools of nursing, therefore, it seems to me nothing is of

more importance than that the public should be made aware of the difficulties inherent in the present system. This can be done most effectively through the medical profession, the churches and a limited number of lay people working closely with the hospitals and the nurses.

"The most provoking problem of those who are deeply interested in the future of the nursing profession is how it may remain a profession rendering its best to people who need it and at the same time secure standards of protection. In age the profession has passed the stage of infancy and is now struggling with all the difficulties of adolescence and the adjustment for maturity is dependent upon an analysis of its problems and an adequate defining of the goal for which it is striving. One recognizes that the desire to protect the nurse from exploitation has been the result of abnormally rapid growth of a system that requires so little for entrance and demands so much for successful achievement. For nursing means not spectacular heroics but monotony, consideration, and inspired service. These requirements call for big souls, not small ones. Nursing at its best merits all the nurse has to give in time, energy and money.

Correcting the Situation

"The public is often unreasonable in its demands. The individual physician must be equipped to handle his problem. Likewise must the nurse be able to do so. If she has come to her profession equipped for real service, having been given an education that will meet today's requirements whether it be in contagious disease, psychiatric care or any of the special fields, the nurse will then feel herself adequately prepared to care for her patient, and at the same time protect herself. She may then take her place among the small group of leaders who help in the development of group ideals. Such individuals cannot be found by the thousands, but they can be found when a good system of selection is inaugurated.

"As a nation we have experienced an age of thoughtless extravagance and waste and have accepted the overproduction of nurses with careless indifference. Let us now set about the task of correcting this condition by securing (1) an informed public; (2) thoughtful and zealous boards of managers; (3) advisory help for the registries; (4) nurses facing their problems fearlessly.

"Then only may we hope for an integration and clarification of the nursing situation."

Hospital Organization Series:

Under the direction of DR. WINFORD H. SMITH

The Philosophy of Hospitalization

By E. H. L. CORWIN

New York Academy of Medicine, New York City

THE prevalence of disease throughout the ages has affected many aspects of human life. The evolution of religious, economic and social institutions has been influenced by it. Whether or not it be true that the decay of certain ancient civilizations was due to malaria or other diseases, there is no doubt that disease decided the fate of many great wars of history, and that the successive waves of such pestilential diseases as leprosy, plague, yellow fever, syphilis, cholera, typhus and typhoid fever, phthisis and erysipelas, smallpox and influenza, which time and again have decimated the population of entire continents, have convulsed the life of most nations of the world and have profoundly influenced social thinking and community organization. Even in antiquity, the importance of a proper water supply, of sanitary disposal of human wastes, of care in the use of food and of segregation of those stricken with loathsome and infectious diseases, was well recognized. The Mosaic code was not the first formulation of sanitary laws.

The First Organized Institutions

Hospitals have been one of the bulwarks that man, since the time he settled in large aggregations, has had to build to defend his civilization against the forces of destruction. They go back to the ancient empires of the Hindus, Egyptians, Persians, Babylonians, Hebrews, Greeks and Romans, and their rise, decay and recrudescence reflect well the development of man's fortunes, his social ideals and conscience, his religious spirit and his scientific achievement.

Early medicine was sacerdotal, a part of a religious rite, and the first organized institutions for the care of the sick were established in connection with temples. In Greece the temples of Æsculapius at Cos, Cnidus, Rhodes and Epidaurus accommodated within their spacious precincts hundreds of sick people. In time, a differentiation among the priests of these temples took place and some of them became concerned exclusively with medical ministrations. Schools were organized and the

æsclepiades became full-fledged physicians whose armamentarium consisted not only of herbs and drugs, poultices, fomentations, massage, baths and gymnasiums, but also of instruments for the performance of such surgical operations as trephination. They developed a high professional code of ethics as attested by the precepts found in the writings of profound antiquity and in the Hippocratic oath which, till this very day, physicians of all countries take upon graduation from medical school.

As early as the end of the sixth century B.C., it was customary for each of the larger communes in Greece to appoint a physician to take care of the sick poor. A special tax, known as the *iatrikon*, was levied to provide for the maintenance of the *demosios iatros* or the communal physician. The place where the physician attended patients was known as the *iatreion*. With the growth of cities, the *iatreion* of the municipal physician became the community hospital as well as the city dispensary. According to Galen (who wrote in the second century of our era) at the time of Hippocrates, in the fifth century B.C., many cities provided physicians with large, light and airy buildings. The private physician's *iatreion* corresponded to a private sanatorium or nursing home of the present day. In connection with these institutions there were numerous helpers, some of whom were medical students, and many of these were recruited from the slaves.

While in ancient Greece the hospitals either were connected with the temples of Æsculapius or were municipal institutions, Rome's distinct contribution to their evolution lay in the organization of military and private hospitals. The large landowners, who had thousands of slaves, established *valetudinaria* on their *latifundia* for the care of their sick slaves by the *servi medici*. In time the members of the landlords' families would resort to these institutions in case of illness, as attested by Seneca. The *valetudinaria* supplied the pattern after which the first military hospitals were organized by the commanders of the Roman legions.

The Greek and Roman hospitals are the direct

precursors of similar institutions founded in the early centuries of the Christian era. "It is well known that hospitality was a sacred obligation of the ancients, and was practiced by them toward the stranger, the sick and the needy, with an abundance which doubtless rendered unnecessary much of the institutionalized charity of today. The *xenodochion*, an asylum for strangers or travelers, was a feature of Athens and of other cities of Greece, and gave its name, as well as its leading outlines, to the later institutions of the Christian fathers."¹

Charlemagne Endowed Many Hospitals

The earliest Christian hospitals were built in the East. We know of the hospitals founded by St. Basil in Cæsarea between 370 and 379 A.D., which were large and of rather complicated organization, and which formed a veritable city of the sick. The fathers of the Church, St. Cosmos and St. Damian, were active in providing medical care in the hospitals. The Emperor Julian imitated the Christian efforts and built hospitals in Constantinople where, subsequently, St. Chrysostom established several hospitals in the true sense of the word. Among the institutions built by Emperor Justinian were open air hospitals arranged in a manner similar to those of the ancient Greek temples.

With the spread of Christianity, hospitals became hospices or shelters for the accommodation of weary palmers and pilgrims, the poor and the lame, as well as the sick. Pious and charitable persons like Helena, the British mother of Emperor Constantine, or the famous Roman matrons, Marcella, Paula and Fabiola, whose eulogies were written by St. Jerome, gave large fortunes toward the building and maintenance of hospitals or asylums. In the year 542, King Childebert founded the famous *Domus Dei* (*Hôtel-Dieu*) at Lyons, and a century and a half later the *Hôtel-Dieu* of Paris was built. Charlemagne endowed a great number of hospitals in the various parts of his vast domains. The responsibility for the administration of these heavily endowed institutions became a matter of considerable importance to the Church, and in time it was entrusted to the monastic orders almost exclusively. The care of the sick became for a period of many centuries the exclusive prerogative of the monks and nuns, and lay physicians disappeared almost entirely.

The Crusades led to the establishment of military monastic fraternities, the most important of which was that of the Knights Hospitalers of St. John of Jerusalem. Enormous wealth was lavished on them by all Christendom, and hundreds of hospitals were built by the Knights along the line of

communication between the West and the Holy Land, some of which were imposing in their style, size and arrangement.

The spread of leprosy, plague and syphilis led to the establishment of lazarettos and to the organization of port hospitals where travelers from infected regions were kept for forty days before being allowed to proceed; hence the name quarantine.

The heritage of Greek medicine fell to the Arabs who established great hospitals and medical schools at Bagdad, Damascus, Alexandria and other cities. They carried their culture with them when they settled on the Iberian Peninsula, and toward the close of the eighth century their hospitals and the school of medicine at Cordova became renowned. Thither came many students from various parts of Europe. In time, the writings of the Arabian scholars were translated into Latin and thus the ideas of Aristotle, Hippocrates, Galen and others, in modified form, found their way back into Europe and created a great intellectual stir.

During the Middle Ages science received an overpowering setback and the hospitals suffered from the stagnation in medical thought and practice. It was not till well into the eighteenth century that the harbingers of a reform movement became discernible. The French Academy of Sciences was the first great scientific body to take cognizance of the need of reform and the recommendations of its committee, published in 1778, dominated hospital planning for over a century and ushered in the era of the pavilion type of hospital. John Howard is another beacon light on the horizon. His study of the hospitals, lazarettos and prisons of the United Kingdom and of the Continent, called attention to the dreadful conditions which existed at the time, and paved the way for reform, which, however, came with painful slowness. No single individual, however, has done more to change the prevailing viewpoints and practices than that singularly gifted and noble woman—Florence Nightingale.

The Foundations of Modern Hospitalization

In America, the hospitals were replicas of their European precursors. The first original plan for an American hospital was that outlined by Dr. John Green, fellow of the Massachusetts Medical Society, in an essay published in 1860. His essay received the prize offered by the city of Boston for the best plan suitable for a city hospital. It dealt not only with details of construction, but with the community policy relative to the care of the sick; the recognition of the importance of research and teaching, the proper classification of patients and the creating of an environment con-

¹Nutting, M. Adelaide, and Dock, Lavinia L., *A History of Nursing*, vol. 1, p. 70, G. P. Putnam's Sons, New York City, 1907.

ducive to the welfare of the various types of patients. He recognized the importance of dispensaries, of convalescent homes, of hospitals for chronics, and stressed the need of segregating in separate wards the sufferers from contagious diseases, certain types of surgical patients, eye patients and neurologic patients. He advocated separate rooms for parturient women, for disturbed or dying patients, and the establishment of a private room service for strangers of means who happened to be overtaken with illness while in the city. He provided in the plans of the hospital a postmortem theater, and facilities for teaching medical students and the younger practitioners. He laid the foundations of the modern philosophy of hospitalization.

Conditions at Bellevue Hospital in 'Seventies

Not until the opening of the present century or thereabouts has a greater contribution been made in this field, although a good many wrote on the subject, and Dr. Charles Alfred Lee of Albany, N. Y., writing in 1863, criticized the then existing state of affairs in the following scathing terms: "It may be truly said that hospitals are in some measure the criteria of a nation's progress in civilization, and the measure of its cultivation of those charities which spring from the heart of a people imbued with philanthropic sentiments. And yet no institutions have been so abused and mismanaged as public hospitals. Originating in the purest benevolence, and supported with the most commendable liberality, they have not only in a great measure failed in accomplishing the objects in view, viz., the recovery of the largest number of sick men in the shortest possible time, but they have even aggravated the very evils they were designed to remove. The laws of sanitary science, imperfectly understood, it is true, until comparatively modern times, have been, for the most part, disregarded and ignored by those who have had these institutions especially in charge, until at length it became a serious question whether it would not prove a blessing to mankind if they were abolished altogether."¹

About conditions as they existed at Bellevue Hospital, New York City, in the early seventies, Dr. W. Gill Wylie had this to say: "At that time, with rare exceptions, the nurses were ignorant and in some cases worthless characters, who accepted the impossible task of attending to and nursing from twenty to thirty patients each. There were no night nurses; the night watchmen—three in number to a hospital of 800 beds—were expected to give assistance to patients requiring attention during the night. The hospital building, originally an old prison and almshouse erected sixty years

ago, had been added to, and was a massive stone structure with three stories and a basement. The wards were only separated from each other by the intervening partitions enclosing the water-closets and bathrooms, which were without ventilation, except as they opened into the wards. . . . The sanitary condition of the hospital was shocking. . . . I saw, while on duty in the wards, patients die from septic diseases contracted in the wards, after the slightest surgical operations or injuries. From 40 to 60 per cent of all amputations of limbs proved fatal."² Wylie became one of the foremost apostles of the evolving concepts of hospital responsibility.

At the time he wrote, and when the Johns Hopkins Hospital was being built, air conditioning and heating were the subjects paramount in the minds of hospital planners and consultants. The new theories about the spread of disease by bacteria threw a new light on the scourge of the hospitals, known as "hospitalism," and added new zest to the efforts to secure ideal methods of mechanical ventilation and heating of hospitals. Dr. John S. Billings was the last spokesman of this school of hospital planners which dominated hospital thought for many decades. Dr. F. Oppert, fellow of the Medical Society of London, writing in 1867 on the construction, interior arrangement and management of hospitals, infirmaries and dispensaries, made the following statement, which illustrates the extent to which the problem of ventilation dominated the entire scheme of construction:

Advocated Minimum Number of Floors

"There are certain reasons why we should avoid having more than two floors in a building intended for a hospital. It is well known that the air in a hospital, as in a private building, ascends from the lower to the upper floor; for instance, we find when the kitchen is in the basement, that the smell of the cooking gradually ascends to the upper stories. From this we conclude that the air of the lower wards finds its way into the upper ones in a similar manner, and this happens in a far less degree in an opposite direction, viz., from the upper to the lower stories. It would follow from this that the air in the upper wards must be more close and less healthy than in the lower floors. In fact, it is often found, and I have noticed it frequently, that the air is sweeter in the lower floors. It is, however, not proved that the patients make a better recovery in the latter, but the views on this point are conflicting. It is known that organic contagions proceed in a horizontal direction, and certainly science is not far enough advanced to show by analysis

¹Lee, Charles Alfred, *Hospital Construction*, reprinted from *Transactions of Medical Society of State of New York*, 1863, p. 3.

²Wylie, W. Gill, *Hospitals, Their History, Organization and Construction*, 1877.

that the air of one part is more pure than that of another.

"Much depends upon other circumstances, such as the price of the building land, etc. In places where land is comparatively cheap, the building may cover a larger space, and may have less elevation. As regards the administrative arrangements, they can be carried on most efficiently where the least number of floors exist. But if the hospital is large, the advantage of not having to ascend so many stairs is counterbalanced by the distance the medical men, attendants, etc., have to walk to perform their duties, and lifts in a great measure overcome objections that are raised against lofty buildings. In fact, it will be generally found that the best plan is to give additional height to those parts of the building where the offices are situated, and to have fewer floors in that portion devoted to clinical patients."¹

The present day philosophy of hospitalization can be said to be the product of the twentieth century. It concerns itself with the communal responsibility toward the problem of disease; with environmental and economic factors involved in the housing and care of the sick, and with the organization and training of the professional staffs necessary for their effective functioning in the interests of the patients and for the advancement of the science and art of healing. These three major concerns are inseparable; they are intermingled into an organic whole; they are the alpha and omega of the hospital problem. As a result, our hospitals have become kindly, humane and scientific institutions. In spite of great specialization which has taken place, they are well integrated and the treatment the patient receives is a joint responsibility of all concerned. Teamwork has become the outstanding characteristic of the mod-

ern hospital organization. Toward a perfect functioning of this collective responsibility are directed the efforts and thoughts of hospital executives, of the leaders of the medical and nursing professions, of civic statesmen, hospital architects and other groups.

We are far from having reached the ideal. *Tempora mutantur*. Neither science nor social thought remains stationary. Performance ever trails behind intention. The broadening sense of communal responsibility opens up new approaches and secures more liberal appropriations for the treatment and prevention of illness, whether from tax funds or private gifts. Scientific discoveries incessantly enrich and render more potent the professional armamentarium to achieve these ends. Technical progress keeps on revolutionizing the environment and rendering it more and more complicated. Structural adaptation and administrative skill never seem to be quite equal to the task of satisfactorily coordinating specialized functions and human relationships.

Hence the innumerable efforts in various directions, more or less successful, more or less costly; hence the increasing power which the hospital displays in attracting into its orbit enterprising spirits to meet the challenge and the opportunity for service it presents; hence the widening scale of the deliberative councils embracing city, state and nation, which of late has assumed international proportions. The large attendances at the international congresses and the active and eager participation of hospital executives of all countries in the work of the newly created International Hospital Association, and its ten standing committees, indicate convincingly that the philosophy underlying hospitalization has outgrown local and even national boundaries and is fast becoming world-wide—a common possession of all mankind.

¹Oppert, F., *Hospitals, Infirmarys and Dispensaries*, p. 15, 1867.

Some Safety Measures to Follow in Using X-Rays and Radium

Helpful information for hospitals regarding protective measures to be employed in connection with the use of x-rays and radium was made known as a result of the recent third Australian Cancer Conference. Prior to the conference, the revised international recommendations on protective measures, as laid down by the third International Congress of Radiology (Paris, July, 1931) had been circulated to all treatment centers for study.

The Australian outlook on this problem was that two factors must be considered: (1) the measurement of the radiation intensities; (2) the tolerance intensity to which a worker could safely be exposed.

It was the opinion of the conference that the best method of measuring the intensity was by the photographic method,

and that a fair estimate of the tolerance intensity was 4×10^{-4} r minutes. Thus in one year of 300 working days a dose of approximately 60 r would be received. As a further precaution, the conference stressed the importance of a quarterly exchange of the nursing staff associated with roentgenologic clinics.

Based on the recommendation of the international protection committee that, for voltage of 400 kilovolts peak a thickness of 1.5 cm. of lead or its equivalent should be provided, the walls of a new block under construction at St. Vincent's Hospital, Melbourne, are being built of barium sulphate. It has been found by test that a thickness of 10 cm. of such brick is equivalent in protective power to 1.9 cm. of lead. The bricks are made of two parts of coarse barium sulphate, one part of barium flour and one part of portland cement. They are tongued and grooved to prevent joint leakage, and the lead sheeting on the ceiling and on the sliding doors in the room overlaps the bricks.

New Private Hospital in Beirut Adopts American Methods

By AMIN A. KHAIRALLAH, M.D.

National Hospital, Beirut, Syria

IN A quiet and central location of Beirut, Syria, overlooking the sea and the mountains, the National Hospital, a modern institution, has just been completed and has opened its doors for the welfare and comfort of the people of Syria and Lebanon.

Having lived and practiced surgery in the United States for a number of years, it has always been my dream to establish in Syria a modern hospital modeled after American institutions, with all the comforts and improvements that have made American hospitals the model for the world. Two years ago I paid a hurried visit to Beirut in order to study the general situation and the advisability of such an undertaking. Several problems had to be studied before a decision could be made. The need for such an institution, the location and site, the size of the building, what class of patients it should cater to and the cost, were all questions that had to be considered.

After due consultation and consideration it was found that there was need for such an institution and that Beirut was the most logical place for the following reasons.

Besides being the political center and chief seaport for Lebanon and Syria, Beirut has been for

centuries the center of learning for the Eastern shore of the Mediterranean. In the days of the Romans and of the Byzantine Empire, especially during the days of Justinian, Beirut rightfully claimed and earned the honor of having the most flourishing law school in the empire. For the past seventy years the city has been the intellectual center for Syria, Palestine, Mesopotamia, Egypt, Asia Minor, Greece and in general for the whole Near East. The American and French universities as well as the other foreign and native institutions, have been potent disseminators of light and culture and the prime factor in the recent renaissance in this part of the world.

Modern Private Hospital Was Needed

Beirut is the chief center of communication by land, sea and air, not only for Lebanon and Syria but also between the East and the West. It is the commercial center for the Near East and most of the travel lines from Europe and America converge towards it. Moreover, before the World War, Beirut had a population estimated at 100,000—I say estimated because no proper statistics were kept in those days—and now it boasts of about 250,000 inhabitants. Besides the native population

While the hospital (in the foreground) is modern in every respect, the exterior design follows native architecture. The building is surrounded by an iron fence. Note the peculiar dome on the building in the background.





Looking north from the roof garden of the hospital, a beautiful view may be had of the blue Mediterranean, the majestic snow capped Sannin and the surrounding country.

there are also many foreign residents—French, Americans, British, Italians.

While the city has a number of hospitals, the accommodations are mainly for the poorer classes, and such accommodations are offered by medical schools and hospitals, the municipal hospital and other charitable institutions. The middle and the upper classes were not adequately provided for and the few accommodations offered to these two classes were not comfortable. The private hospitals that exist are mostly remodeled old homes and the accommodations they offer leave a great deal to be desired.

The need for such an institution having been realized and the location decided upon, the next problem was to determine its size. Since Syria is primarily a Mohammedan country it was desirable, even essential, to have separate floors for men and for women. The physicians' and administrative offices had to be accommodated on a third floor.

Another floor was designed for the kitchens, the dining rooms, the storage rooms and the servants' quarters. Thus from the outset it was evident that at least four floors were necessary. A fifth floor was added to accommodate the house surgeon, the superintendent, a large assembly room and an isolation room for cases that might develop an infectious condition while in the hospital.

Plans Drafted in New York City

The number of beds was the next consideration. Inasmuch as two floors were needed for the patients, it was found that it was just as economical to run a fifty-bed hospital as a thirty-bed hospital—the overhead expenses being the same with the exception of a few more nurses and the extra food, both of which are an insignificant item in Syria.

The site on which the hospital is built is one of the prettiest and most healthy in Beirut. Built on a little elevation, the hospital occupies a small city

The library and consultation room is on the first floor. The room is attractively furnished with wicker furniture, which makes it a pleasant meeting place for the staff.



block with the main street on the front and a side street on each side. A garden surrounds the whole building. To the rear of the building there is an ambulance road and back of this are a laundry, an ambulance room and a postmortem room.

The plans were worked out in New York City and were modified in Beirut to suit local conditions. In planning and equipping the hospital no effort or money was spared in putting into it everything that would promote the comfort and safety of the patients. The building is of concrete and sandstone with hollow tile partitions. The floors in the corridors and bathrooms are of Italian marble. The floors in the operating rooms, the delivery room and the sterilization room are of imported ceramic tile, and the rest of the floors are of mosaic tile. All corners as well as the junction of the walls with the ceiling and the floor are rounded to prevent dust collection. Cross ventilation is secured by means of window and door ventilators. The doors and windows are screened with antique bronze screening. The sanitary fixtures are vented and revented. There is a fire hose on each floor, which is connected with an eight-ton reservoir on the roof. The maternity and operating room wing is separated from the other parts of the hospital. The kitchens, the dining rooms and all the other utilities are in the basement, thus keeping the rest of the hospital free from odors and noises. A dumb-waiter carries the food in bulk from the basement to the service kitchen on each floor. A large hospital elevator, equipped with modern safety devices, is installed for the comfort of the patients and their relatives and friends. Lighting in the hospital is of the indirect type, giving good light and preventing glare. A central heating plant with an oil burner ensures warmth and comfort during the cold weather. Two roof gardens and a solarium are on each wing of the top floor.

Surgical Specialties on First Floor

The building consists of four floors and a basement. It is rectangular in shape, with a central body and two wings. The front faces the north and commands a good view of the sea and the mountains. The rear faces the south and commands a good view of the encircling hills.

The basement contains the main and special diet kitchens, the dining rooms for the servants and for the nurses, a pantry and ice room equipped with electric refrigeration, two bedrooms and two wards for the servants, a bathroom for the servants, a furnace room and five large storage rooms.

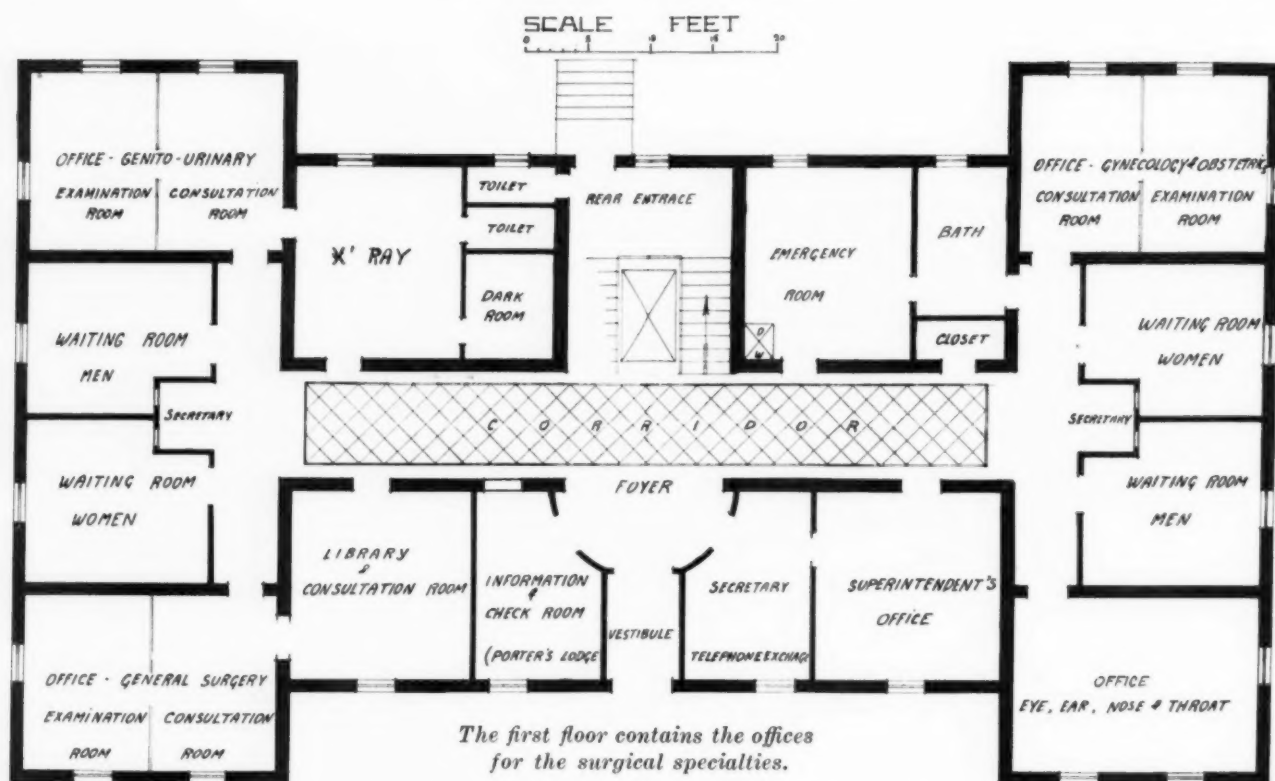
The first floor is designed for a complete set of offices for all the surgical specialties, to which work the hospital is devoted. The vestibule leads



Two large iron grille gates of native design lead to the main entrance of the National Hospital, Beirut.

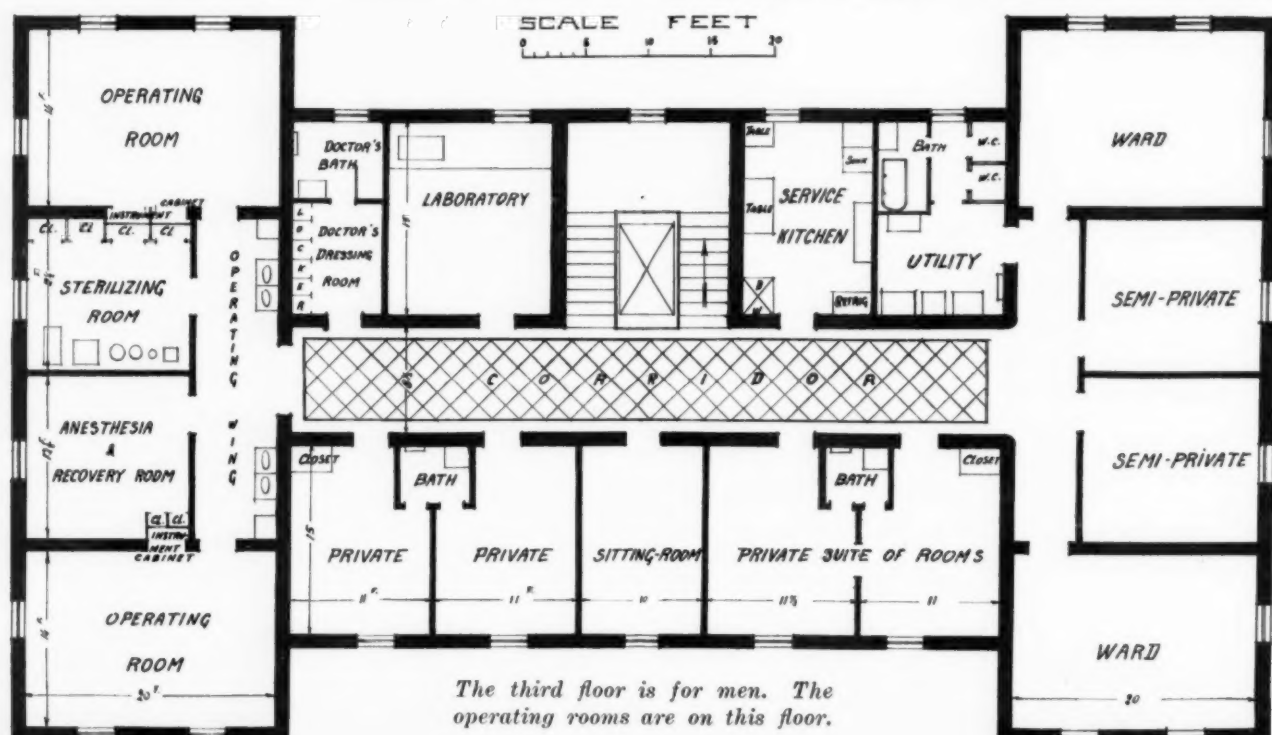
to a foyer. On the left side of the entrance is the information desk and check room (which also serves as a porter's lodge at night), and to the right is the secretary's office and the telephone exchange. Four offices, consisting of a consultation room and examination room each, are for general surgery, genito-urinary surgery, gynecology and obstetrics and eye, ear, nose and throat. Between each two of the offices are two waiting rooms, one for men and one for women. An alcove between the waiting rooms serves as a secretary's station. On this floor also are the library and consultation room for the use of the staff, the x-ray room with its dark room and toilet, the emergency room and the superintendent's office. A rear entrance on this floor serves as the ambulance entrance.

The second floor is the women's floor. The east wing is reserved as the maternity wing. It has two private rooms, one semiprivate room, one ward, a delivery room, a nursery and a bath. A



large French door separates this wing from the rest of the floor. The rest of the floor has four private rooms, with a bath between each two rooms, two semiprivate rooms, two wards, and a sitting room. A service kitchen that is connected with the main kitchen by the dumb-waiter serves this floor. A utility room and a bathroom serve the semiprivate and ward patients. The nurses' station is in the central corridor on this floor.

The third floor is the men's floor. The east wing is reserved as an operating wing. It has two operating rooms, one for major surgery and the other for minor surgery and eye, ear, nose and throat work. Between the two operating rooms are the anesthesia and recovery rooms and the sterilizing room. Near each operating room in the corridor is a battery of special scrub-up basins. The floors of the operating rooms are of ceramic tile which



This view looking northwest from the roof garden shows the Mediterranean and a section of the city. The tall native trees add beauty to the scene.



does not stain from the regular medications and antiseptics used in the operating rooms. The walls up to the height of six feet are of white china, mottled with green. All the corners as well as the junction of the walls with the ceiling and the floor are rounded. The instrument cabinets are built in the wall. The operating rooms are equipped with shadowless lights. Adjacent to this unit are a doctors' dressing room and bath and a laboratory that is equipped for regular hospital work. The sterilizing room contains an autoclave, a utensil sterilizer, two water sterilizers, an instrument sterilizer and a still, and built-in steel cabinets for the sterile supplies.

The central portion of the fourth floor is built up, leaving the two wings for roof gardens and a solarium. On this floor there are a large assembly room, an isolation room with a bath and nurses' station, the superintendent's bedroom and bath, an intern's bedroom and bath, a storage room for medical and surgical supplies and a small room for storing the roof garden furniture.

Future Expansion at Small Cost

The solarium, with its special glass windows, serves for sun treatments. With at least nine months of sunshine and a large number of cases of surgical tuberculosis the solarium will probably be in great demand. The roof gardens command a beautiful view of the blue Mediterranean, the majestic snow capped Sannin and many villages.

The building is planned in such a way that by building up the two wings on the fourth floor the capacity of the hospital can be increased by twenty-four beds at a small cost. The roof gardens and the solarium would then be moved to the roof of this addition. Another twenty beds could be added by building up the rear of the wings. Thus, even

if the capacity is increased to 100 beds, the building would still be compact, easy to administer and easy to service.

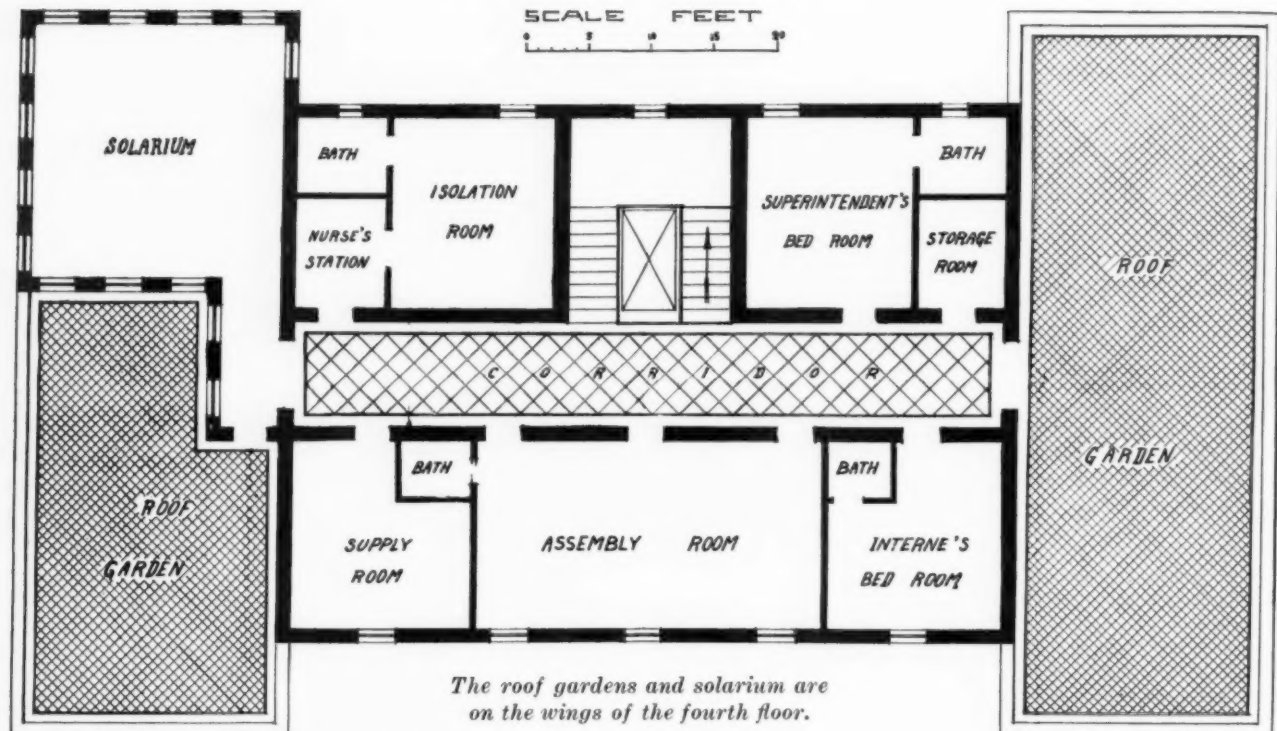
In a country where typhoid fever and dysentery are endemic, sanitary installations and equipment must be of the best. The difficulty of finding capable artisans together with the poor water pressure made this problem a fairly difficult one. However, with careful planning and patience the problem was solved.

Slop Sinks Used for First Time

Every fixture in the hospital is vented and re-vented. The pipes and drains are concealed in the walls and yet they are easy of access. Separate drain pipes for the water and for the refuse were installed, which is the usual practice in hotter climates. Two septic tanks have been installed for use until the city drains are in working order. The bathtubs are of the square, built-in type, and are equipped with mixing faucets and a shower. Each lavatory and sink has mixing faucets and stopcocks. The mixing faucets installed in the operating rooms and the offices are elbow operated. The bathrooms have marble flooring and china walls. Slop sinks were used for the first time in Syria.

A special bedpan emptier that is built in the wall and a bedpan sterilizer and rack are installed on each floor. The emptiers are connected directly with the reservoir on the roof to ensure sufficient pressure.

Since the majority of the patients are accustomed to the "Arabic" type of water closet (generally a slit in the floor over which they squat), it was necessary to install two types of closets—one a regular European or American closet and the other a modified closet that allows



the patients to squat, and to which an elbow and a revent could be attached. We have found the modified closet satisfactory for hospital use as it prevents any infection from the seats and allows of squatting which helps prevent constipation.

Four lines of piping connect directly with the city supply. One line serves the kitchens, one the offices and the operating rooms, one the drinking fountains and one the reservoir. All the bathroom fixtures receive their supply from the reservoir to ensure good pressure and quick filling of the tanks, and all the water that might be used for drinking is brought directly from the city supply.

The private rooms and the semiprivate rooms are painted light green and the wards are a light French gray. These colors match the beds, the bedside tables and the bedspreads in the various rooms, and carry out the color scheme throughout. In Syria, where the light is so bright, this color scheme is restful.

All the windows are of the American type. They are equipped with ventilators that permit ventilation without drafts. One-piece hollow doors are used, with an inch air space in the door to help prevent noise. The transom is an inverted shutter that allows ventilation and cuts out light from the corridor.

The top floor of the building has a ventilated double ceiling with a three-foot air space between the roofs, making the top floor cool despite the hot sun that strikes on the concrete roof.

The private and semiprivate rooms are equipped with modern beds of a soft green color. The beds

are equipped with folding crank handles, fracture bars, irrigator rods, a head attachment for a mosquito net bar and four-inch rubber casters. Inner spring mattresses and goose and duck feather pillows add much to the comfort of the private and semiprivate patients.

The ward beds are of a light French gray color. They are equipped with a back rest, a fracture bar, a mosquito net bar and rubber casters. They are also equipped with inner spring mattresses and feather pillows.

Every office, every floor and every private room has a telephone. The telephone exchange in the secretary's room gives an interhouse connection as well as a city connection.

Who Is the Ultimate Beneficiary?

In a short article in the hospital bulletin entitled "Who Is to Benefit and How Do They Secure These Benefits From the Community Chest?" H. G. Fritz, superintendent, Cone-maugh Valley Memorial Hospital, Johnstown, Pa., points out that while during the fund raising period emphasis is laid on the fact that the hospital is to receive a certain amount of money, in reality the community is receiving that money, because the allotment to the hospital is based upon the amount of free work that is done, thus relieving the community in one form or another of paying for it.

He says, "Is it not, therefore, more nearly correct to say that the people of the community chest area who are sick in addition to being poor are to receive approximately 13,000 free days of hospital care during the next twelve months rather than to say that the Memorial Hospital is to receive a certain amount of money?"

The Hospital and the Law*

By EDGAR CHARLES HAYHOW

Superintendent, Paterson General Hospital, Paterson, N. J.

INSTITUTIONAL taxes may be classified into four kinds: property, income, inheritance and license. As a general rule statutes provide for the exemption of property used for charitable, educational or religious purposes, the method varying in different states. In general, however, exemption from a general property tax does not by necessity exempt corporations from paying inheritance, license or corporation taxes.

Charitable corporations may not hold property in foreign countries free from taxation (Delaware County *versus* Sisters of St. Francis., Del. County Ct. Rep. 149-1876). Property owned by charitable corporations that is leased for other than charitable purposes is not exempt from taxation, although property held by an institution and used for purposes necessary to the proper performance of the charity is exempt. This includes nurses' quarters, servants' quarters, farms, in fact all property applicable to the exact interpretation of the state statute. Many cases to the contrary are on record, however, holding that land occupied by nurses' quarters is subject to a property tax. Public hospitals owned by the government are, of course, not taxable.

Many statutes have been enacted concerning hospital taxation and as many precedents have been handed down from court interpretations. When questions present themselves, expert legal advice should be sought and followed.

Security of Endowments

It is assumed that a private hospital maintained for the care of the sick, at a loss, must receive outside financial assistance to meet its obligations. In view of this, laws provide that institutions may receive: (1) monies appropriated through municipal aid and public subsidy; (2) gifts, grants and bequests, according to specific terms of trust, further providing that the proper use and care of the funds are the duty of the directors or trustees of the institution. It must be remembered that endowment funds are trust funds and must be used exactly in accordance with the wish of the donor as determined in the gift or bequest. It is debatable whether it is good management to tie up too many funds with too detailed specifications. The

endowed hospital may become lopsided because income from endowment funds cannot be used to the best advantage. Then, too, the policies of institutions change, practices of medicine recognized today are obsolete tomorrow and often, in the course of time, the original intent of the donor loses its significance and value.

Many states empower municipal authorities to appropriate endowment or public subsidy to institutions for the specific care of indigent cases, for further extensions or for ambulance service. State statutes definitely prescribe what constitute proper investments for hospital endowment funds. Suffice it to say, every possible security and safety must be maintained, as the trust is given in good faith for good purposes. The mishandling of endowment funds will discourage bequests.

Regulations for Institutional Inspections

Some thought should be given to the relatively new idea of community trusts. This type of trust is controlled by a board for which a safe plan of perpetuation of proper membership is worked out. A donor may place a sum in the hands of the trust, designating a particular use for it, provided it is for the good of the public. As needs change, however, the trust may make a different use of the gift, if a change seems wise.

Each state has provided specific statutes governing the licensing and inspections of institutions in its respective territory, although there is no interstate uniformity in either the nomenclature of the governing bodies responsible for the license and inspection of the institutions, or the frequency with which such visitations must or may be made.

Connecticut, for example, provides that "the state board of charities may inspect all almshouses, asylums, hospitals and institutions . . . in order to ascertain whether their inmates are properly treated. The state hospitals for the mentally ill are to be visited once every three months; the commissioner of health is to make an inspection once each year of all public hospitals and asylums."

The Delaware law reads that "the state board of health has the power and authority to make special inspection of hospitals . . . and other institutions."

The Idaho law provides that the state tuberculosis commission is to visit each district tuberculosis hospital semiannually for the purpose of

*The first part of this article appeared in the February issue of THE MODERN HOSPITAL.

inspecting all books, papers and accounts, and informing itself as to the welfare of the patients. County boards of health are authorized to visit "other public institutions" at least once a year.

In Kansas the board of health is required to inspect each institution semiannually. Montana law permits the state board of health to make an inspection once in each year, and at such times as it may be directed to do so by the governor. Virginia authorizes the state board of charities and corrections to inspect hospitals at any time.

In South Dakota the commissioner of insurance is required to inspect all hospitals accommodating more than 100 persons and to determine whether or not they are safe and provided with proper exits and means of escape from fire.

Legislation for Maternity Hospitals

New York State provides that all hospitals accepting public patients (those whose service is paid in full or in part, by public subsidy) are subject to inspection by the state board of charities, but limits this inspection to the physical care of the patient, that is, quality of food served, clothing, proper housing and the suitability of buildings.

In comparatively recent years much legislation has been enacted concerning the creation and administration of maternity and lying-in hospitals. Practically every state demands a separate and distinctive license from various agencies before maternity hospitals may be established or operated.

As is the case in granting licenses to general hospitals, there is no uniformity as to the agency vested with legislative power to authorize maternity institutions. The department of public welfare has this power in Idaho; Connecticut provides that the mayor, the board of health or the health officer in the town assume this responsibility; Alabama licenses maternity hospitals through its child welfare department.

California goes so far as to create separate statutes with reference to delivery rooms and specifically states that "The delivery room shall be furnished with a delivery table or bed, an instrument table, an irrigating apparatus, basins and pitchers. There shall be an ample supply of sterile linen and dressings. Drugs ordinarily needed shall be kept in the room at all times." The same stipulation is made for nurseries, and the statute calls special attention to the fact that clean mattresses covered with rubber sheetings, washable pads, clean blankets, separate beds, stationary bathing facilities and wall thermometers must be provided.

Lack of space prohibits a detailed review of all the laws concerning maternity hospital legislation, but a few of the more important sections included in the individual state codes follow:

Arkansas provides that fire drills must be carefully worked out and held at least once a month; Minnesota states that the presence of an unmarried woman in any maternity hospital for the purpose of confinement must be reported to the hospital's board of trustees as soon as the facts are known.

Section 4652 of the Minnesota law provides that in the case of a child dead at birth a certificate of birth having the word "stillbirth" inserted in place of the name, and also a certificate of death shall be made and filed with the local registrar. A certificate is not required of a child that has not advanced to the fifth month of uterogestation. A similar provision is made in many state codes, the only difference being in the length of the period of uterogestation.

Ohio stipulates that no maternity hospital may admit a child without its mother, except in the case of an emergency.

Many states provide that unless a child is breast fed, any artificial feeding must be on prescription and under the direction of a legally qualified physician.

In most states special provision has been made for the registration of both births and deaths with the local registrar or the bureau of vital statistics, the period granted for such registration ranging from one to ten days after delivery. Regulation is likewise made as to the responsibility for completing and filing the necessary certificates. Many states have specific sections concerning conditions of ophthalmia neonatorum, and the general ruling is that the presence of such conditions must be reported at once.

Each State Requires Record Keeping

Hospital records are one of the most important of institutional details, for without a record of performance there would be absolutely no way to establish precedents or procedures.

Each state provides that a record of all personal and statistical history relative to a patient in an institution shall be made in a permanent register. The name, the address, the nativity, the sex, the age, the color and the occupation of the patient, together with the presence of infections, communicable, contagious and industrial diseases, must be reported to the individual health authorities as soon as detected. The physician in charge is required to specify the nature of the disease, and to give his opinion as to where and when it was contracted.

Special legislation has been enacted for institutions established and maintained for the treatment of persons addicted to the use of alcohol and drugs. It is generally accepted that when such

persons are treated in general hospitals, full details concerning the case must be reported at once. Morphine, cocaine, opium or other deleterious drugs administered to patients under treatment in a hospital must be prescribed under the direction of duly licensed and registered physicians and a permanent record, consisting of the name of the patient, the date, the dosage, the disease and the name of the physician must be recorded.

Sanitation and Nuisances

An important function of records is their use as evidence in court proceedings. Should hospitals provide insurance companies, attorneys and other interested parties with records regarding hospital patients? The general rule is that hospital records are private and must not be divulged without the written consent of the patient. Many states differ as to the admissibility or inadmissibility of using hospital records as evidence in court procedures, but it rests as a definite practice that hospitals need not submit their records as evidence or otherwise without proper subpoena from the courts or legislative authorities.

State laws respecting sanitation and affairs of public hygiene are generally expressed through the medium of municipal ordinances, and often are classified in special enactments headed "Sanitary Nuisances." These matters are usually under the immediate supervision of state, county, township or city boards of health, and health commissioners who regulate and control the disposal of garbage, the removal of remains and their proper incineration and other hygienic measures.

Considerable legislation has been passed dealing with the hospital as a nuisance. Many cases have been referred through legal channels for court opinion as to what constitutes a nuisance, but there is a general agreement that each case must be decided upon its individual merits. Such questions as noise, the proximity of the institution to residential neighborhoods and the declaration of the institution as noxious and offensive have been debated. Unless hospitals are established for the care of contagious diseases or can actually be classed as pesthouses, or as a danger to health, the burden of proof seems to favor the hospital.

New Jersey is one of the few states to provide special legislation requiring persons or corporations to obtain consent of the local governing body within whose limits a hospital for contagious diseases is to be constructed. The New Jersey law also says that the state board of chosen freeholders cannot maintain a hospital for contagious or infectious diseases within 250 feet of any public highway or any dwelling house or other inhabited dwelling.

The performance of an autopsy without proper consent by the next of kin is a misdemeanor, and both the hospital offering the facility and the physician performing the examination can be held liable. Autopsies may generally be performed in institutions by order of the board of health or the coroner to ascertain the cause of death. Complete records should be kept in the institution's files of all findings. A decision rendered recently by one of the lower courts in New York, however, held that a hospital was liable for conducting an autopsy, which had, in fact, been performed by the municipal coroner (medical examiner) to ascertain the cause of death on the grounds that the hospital had no reason to refer the case to the office of the coroner in the first instance.

A surgical operation or the administration of an anesthetic should not be permitted, except in grave emergencies, without the written consent of the patient involved. In the case of children or in the case of adults who are not in a condition to submit to such consent, written permission must first be obtained from the nearest of kin. Where immediate operation is warranted, before written permission can be obtained, it is recommended that a consultation of physicians make the fact known in writing on the patient's history for the safeguard of any subsequent question. These rules concerning operations, anesthetics and autopsies are cardinal principles and must be adhered to strictly.

Workmen's Compensation Laws

In the past few years a new development of hospital practice has come about in the establishment of specific laws providing for the necessary medical, surgical, nursing and hospital service for persons injured or incapacitated in the line of their employment. These laws, known in the majority of states as the workmen's compensation laws, bear a dual relationship to the hospital organization; first, as they affect the hospital as an employer that is responsible for the medical care of its injured employees, and, second, (the bulk of compensation work) as the hospital plays a part in providing necessary medical, institutional and nursing service to persons injured in line of duty in their respective employments.

The interpretations of workmen's compensation statutes vary in every state.¹ The general interpretation is that employers must make provision through insurance or otherwise to provide injured employees with such reasonable medical care and treatment as their injuries may require, and also additional financial compensation for partial

¹Missouri, Mississippi and South Carolina do not have workmen's compensation laws; North Carolina has no compensation laws affecting hospitals.

or complete disabilities resulting from the injuries. In designating the type of hospital service that the injured person shall receive, many states have set the ambiguous standard that hospital service and rates shall be in agreement with the service and rates "that prevail in the same community for similar treatment of injured patients of a like standard of living." A review of the compensation laws of the various states shows that, to a greater or lesser degree, each state provides a minimum or maximum standard for the period of disability allowed, the financial payment for services, the right to select personal physicians and the extent of compensation allowed for various injuries.

New Jersey's Lien Law

Each state that has a compensation law makes provision for a special state industrial commission within whose power it is to adjudicate all compensation claims, and to act as a "clearing house" in the settlement of cases referred to it for adjustment by either the state, the employer, the insurance carrier, the employee, the hospital or the private physician.

The federal government has established the United States Employees' Compensation Commission, which acts as a governmental agency to administer all compensation affairs affecting civil service employees. The provision is made that when practical government physicians and hospitals are to provide this service, otherwise private physicians and hospitals may be used.

State employees must look to their individual state industrial commissions for the settlement of personal claims.

The following summarizes the provisions of New Jersey's lien law as affecting hospitals and similar institutions:

Section 1. Every charitable association, corporation or other institution maintaining a hospital in this state, supported in whole or in part by private charity, or owned, operated and/or maintained by any municipal body, shall have a lien upon all rights of action, suits, claims, counter-claims or demands of any patient receiving treatment, care and maintenance on account of personal injuries received in any accident resulting from negligence of any other person or corporation, which the injured may or shall have or maintain against the negligent party for damages, for the amount of reasonable charges for such treatment at ward rates up to the date of payment of such damages,¹ provided:

¹As originally adopted, Section 1 extended the lien to charitable associations, corporations or other institutions only for the amount of the hospital charges. Subsequently the words "reasonable charges at ward rates up to the date of payment of damages" were inserted, and in 1931 the act was extended to hospitals maintained and supported by municipalities, including counties.

A written notice shall be filed in the county clerk's office of the county in which such injuries occurred prior to the payment of any monies to the injured as compensation for his injuries, containing: (1) the name and address of the injured person; (2) the date of the accident; (3) the name and location of the hospital; (4) if known, the name of the person, the firm or the corporation alleged to be liable.

After filing it shall be the duty of the hospital to mail, postage prepaid, a copy of such notice, with a statement of the date of filing, to the person, firm or corporation alleged to be liable, if their name and address shall be known.

Section 2. The lien of the hospital shall attach to any verdict, report, decision, decree, award, judgment or final award in any court of record of New Jersey, or any public board or bureau, and any proceedings brought by the injured person or by his estate in case of death as a result of such injuries, as well as to the proceeds of any settlement thereof or the settlement of any such claim effected by the injured with any other person or corporation.

Section 3. After the filing of the notice, no release by the injured person shall be valid as against such lien, and the person, firm or corporation making any payment to the injured or his representatives as compensation for injuries shall, for a period of one year from the date of such payment, remain liable to the hospital, to the extent of the full consideration paid to the injured person. Any such hospital may, within such period, enforce its lien by a suit at law against such person, firm or corporation making such claim.

Section 4. The county clerk shall keep a hospital lien docket in which he shall enter the name of the injured person, the date of the accident and the name of the hospital making the claim. The county clerk shall make a proper index and shall be entitled to twelve cents for filing each claim, and at the rate of eight cents per folio for such entry made in the lien docket, and six cents for every search in the office for such lien claim.

Nurses' Training Schools

The act also provides that the person, firm or corporation legally liable or against whom the claim shall be asserted for compensation for such injuries, shall be permitted to examine the records of the hospital with reference to the treatment, the care and the maintenance of the injured person.

In the past two decades considerable legislation has been enacted affecting the nursing profession, first, in relation to the establishment of accredited

nurses' training schools; second, state provisions regulating graduate nurse registration.

There seems to be considerable confusion in the minds of many persons between state requirements governing nurse training, and the rules and regulations instituted by individual hospitals with reference to their respective schools. For example, a certain state may establish one full year of secondary or high school education as a prerequisite for admission to a registered school, while an individual training school within the state may require all its students to possess a full high school education for admission.

Is the ruling the same in all states and in all hospitals affecting the entrance age, the prerequisite education and the qualifications for young women desirous of entering nurses' training schools? May a graduate from any hospital training school in one state practice nursing in another state? Is there any uniformity in the various states as to the length of the training course, the required number of teaching hours or what constitutes the subjects making a standardized curriculum? Are the laws comparable in the various states with reference to the establishment, the organization and the operation of nurses' training schools in hospitals? Do all hospitals that maintain accredited schools submit to the same state supervision as other educational institutions within the state?

Entrance Requirements Differ

Were one answer to suffice in answering these questions, it would be that there is absolutely no uniformity or standardization of nurse legislation among the various states, with the possible exception that each state sets forth comparable salient provisions governing training school operation and nurse registration. Most states provide that a specific board or committee (usually called the state board of nurse examiners) shall supervise these activities for the state. The rules and regulations in the main include various requirements for the establishment of the school, the size of the hospital, the size of the faculty, the diversity of cases, the records of students, the interstate reciprocity, the registration fees, the sanitation and operation of nurses' homes and the details governing the specific educational activities.

The prerequisite educational requirement for admission to nurses' training schools ranges from an elementary school education to a four-year high school course. Approximately 14 per cent of the states require an elementary school education, 59 per cent require one year of high school, 22 per cent require two years of high school and 5 per cent specify a full high school course for admission.

Connecticut, Delaware, the District of Columbia, Illinois, Maine, Michigan, Mississippi, New Hampshire, New Jersey, New Mexico, New York, South Carolina, Tennessee, Texas, Virginia, Washington and Wisconsin agree that the period of instruction must not be less than two years. Arizona, California and Nevada specify twenty-eight months' instruction. Kansas and Oklahoma require thirty months, and Alabama, Arkansas, Colorado, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Montana, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, South Dakota and West Virginia specify a three-year training course for nurses. A few states make further provision for affiliated college schools.

State Laws Regarding Nursing Schools

There is no general agreement as to the size of the hospital or the number of patients necessary for the establishment of a nurses' training school. Idaho specifies thirty beds, with a daily average of twenty patients; Louisiana classifies its schools into A, B and C groups, in accordance with the size of the hospital; the District of Columbia requires fifty beds, with thirty patients as a daily average; Arizona specifies "not less than seventy-five and 100 beds," and a daily average of fifty patients; Arkansas and Colorado stipulate not less than twenty-five beds, with a daily average of fifteen patients. Most states fix the minimum number of operations and obstetrical cases that a hospital must handle monthly in order to maintain a nurses' training school, and also stipulate the minimum number of obstetrical cases to be attended by the student each year. North Carolina regulates the number of hours the student may be employed each day. California's laws enumerate in detail the necessary equipment for demonstration rooms and laboratories, and specify the requirements for proper living conditions for student nurses. Arizona requires that one waitress shall be provided for every twenty students in the dining room, unless the cafeteria system is used. Arkansas stipulates the period to be allowed each year for illness; Colorado specifies that prophylactic measures must be carried out for the benefit of nurses caring for communicable diseases.

Regulations differ in the various states concerning reciprocity of license to practice nursing. Most states issue certificates without examination to nurses who are registered in other states that have equivalent requirements. The District of Columbia reciprocates with New York, Maryland, Tennessee, California and Oregon. Kansas and Kentucky reciprocate with those states that accept their

nurses on the same reciprocal basis; Colorado and Indiana permit reciprocity privileges without examination to all nurses who have served in the United States Army or Navy, while Indiana requires an honorable discharge from the service.

California, Florida, Maryland, Indiana, Michigan, New York, Oklahoma, Pennsylvania and Virginia have specific legislation governing the training and licensing of trained attendants.

The Accident Within the Institution

Laws differ in the various states concerning the requirements and cost for registration, and the fee for renewal privileges. The majority of states specify that applicants for registration shall be twenty-one years of age, and also that a grade of 70 per cent shall be attained in the final state board examinations.

In general, the relation of litigated cases and hospitals rests in subpoena of professional members of the institution or the case records for reference purpose. All too frequently, however, a case presents itself where the institution itself is the accused. A good rule to bear in mind is that every accident within the confines of the hospital that may involve a lawsuit probably will involve a lawsuit, therefore every possible safeguard and record of the facts should be made to ensure a thorough knowledge of the case.

What information of legal importance should be passed on to the intern, to the graduate nurse, to the student nurse, to the clerks, to the department heads and to the employees in general? A manual should be prepared for its entire staff by every hospital calling attention to the salient points of the law and to the danger signals that may involve the hospital in litigation and that should be referred to the administration, the directors and the legal counsel at the time of the occurrence rather than months afterwards. A systematic check should be made by the administration to ensure compliance with the rules and regulations.

The hospital personnel must be impressed with the fact that the courts, in general, and the administration, in particular, are interested in facts, not opinions. If an intern, for example, is called upon to render professional aid, either on the ambulance or in the accident room to persons suffering from conditions of police concern, the intern should immediately notify the hospital and police authorities in accordance with the procedure outlined in the manual. The intern should give all the facts to both authorities, but he is not called upon for his professional opinion as to the whys and wherefores. If the case eventuates into a coroner's case, it is the coroner's prerogative to enter into such detail as he may deem necessary,

and to give such advice as he may feel is warranted.

Thousands of cases may be cited of apparent negligence on the part of hospitals, such as patients falling out of bed, patients burned by hot water bottles, visitors injured while visiting patients, ambulance collisions, patients falling out of windows, injured employees, elevator accidents, deaths due to cross infection, autopsies performed without proper authorization, the disposal of dead bodies, lost personal property and the escape of patients. Whenever a case of this nature occurs, employees should immediately report the matter to the superintendent, through the proper channels. That is, student nurses should report the matter to the supervisor, the supervisor in turn should report to the director of nursing, and the latter to the superintendent.

The superintendent should receive a complete record of the accident, accompanied by statements from every person familiar with any of the facts. The superintendent should then prepare a summary record of the case for permanent file and a copy of this should be sent to the legal counsel.

Every hospital executive should have a knowledge of the laws affecting hospitals in his own state and the laws of other states that apply to interstate hospital activities.

Must Follow Changes in Laws

Books on medical jurisprudence are important as they clearly outline the civil laws applying to medical science, to the physician and to the patient. Evidence, admissible records, licenses, agreements for operation, civil malpractice, laws affecting insanity, anesthetics and similar points are discussed in such books, and this accurate knowledge is beneficial to the hospital administrator. A simple review of business corporations has been offered and I recommend the volumes of Charles W. Gerstenburg and Thomas Conyngton, referred to in the first part of this article, which appeared in the February number of THE MODERN HOSPITAL.

Those persons interested in special medical and social fields should review laws applying to those special fields.

There are two points that I should like to emphasize: (1) Every superintendent and student of hospital management should survey the consolidated hospital laws affecting his own state, and should keep informed on the changes that are continually occurring in hospital legislation. (2) Superintendents and students should never lose sight of the tremendous importance attached to the legal side of administrative performance. They should refer to the proper institutional authorities every incident likely to result in litigation of any sort.

Pledges From 4,000 Persons Built This Modern Hospital

By F. M. SHIELDS

Chairman, Board of Managers, Harrington Memorial Hospital, Southbridge, Mass.

SOUTHBRIDGE, Mass., and the surrounding communities comprise a population of 18,000 people. The Harrington Memorial Hospital is the only hospital within twenty miles of the center of the district. Its erection was made possible by a remarkable display of public spirit when the community raised \$231,000 in order to take advantage of a gift of \$150,000 from Mr. and Mrs. Charles D. Harrington.

The present capacity of the hospital is thirty-six beds, not counting bassinets, but the nurses' quarters, which at present are in the hospital building, provide for a quick expansion to sixty-six beds, with fourteen bassinets. The hospital is operating with an average of twenty-five patients.

Much Preliminary Planning

The plans for the Southbridge institution were carefully drafted several years before construction was begun. They were based on the best advice and statistical evidence that could be gathered. More than a year was spent by a prelimi-

nary committee in gathering data concerning the hospital requirements of Southbridge and of similar communities. The project had been in the mind of Mr. Harrington, a retired manufacturer, for almost twenty-five years. An exhaustive study of the methods used in other hospitals preceded the actual opening of the institution.

Educational Campaign Conducted

Primarily, the Harrington Memorial Hospital is a community enterprise. While it is entirely separate from the town government, every effort has been made to establish in the minds of the community the idea that the hospital belongs to each individual in the district. Nearly 4,000 pledges were received in the financial campaign.

During the year that the hospital was being erected, a concerted studied effort was made to acquaint the community with the high standards that were to be maintained, and at the same time to break down the public's fear of a hospital. The interest that was aroused was evidenced by the



The Harrington Memorial Hospital was made possible through one large gift of money and the contributions of approximately 4,000 people of Southbridge, Sturbridge, Fiskdale and Charlton, Mass.

10,000 persons who inspected the hospital on the opening day.

The Harrington Hospital Corporation comprises 315 members, all of whom have been active either in raising funds for the hospital or in some other phase of the work.

The management of the corporation is in the hands of a board of trustees of forty-two members, who in turn delegate the actual management of the hospital to a board of managers of twelve men, divided into the following groups: finance committee, building and grounds committee, house committee, publicity committee and women's auxiliary.

Medical Staff Divided Into Three Groups

The rules and by-laws governing the medical conduct of the hospital, as drafted by the trustees, have been approved and adopted by the Southbridge District Medical Association. The medical staff is divided into three groups: (1) active, (2) courtesy and (3) consulting. The active staff includes physicians of the community who are approved by the medical society and trustees, and who intend to devote a considerable portion of their professional time to work in the hospital.

The courtesy staff is composed of other local physicians who are accorded the privileges of the hospital for their practice. Physicians and sur-

geons from outside communities are included on the consulting staff. This group has all the privileges of the active staff and may care for patients at the hospital as well as being available for consultation.

A consulting staff of over thirty outside specialists, having offices in near-by cities, has been carefully built up, and considerable importance has been attached to this group.

Cost Was \$4,400 Per Bed

The architects, Derby, Barnes and Champney, Boston, took as their primary objective the erection of a modern hospital that would be homelike in its appearance, both inside and out. Those who purchased furnishings followed the same policy. Walls tinted in cheerful colors, flowered draperies, reproductions of antique furniture, even in the children's ward, help to banish the institutional aspect.

Due in part to the care with which the original plans were laid, to the alertness of the building committee and to the care that was given to daily inspection, the building was erected and equipped at a cost of \$4,400 per bed.

The first floor contains two one-bed wards, one of which is the isolation room, two two-bed wards, two three-bed wards and one six-bed ward. The waiting room is on the right of the entrance hall and the hospital office and superintendent's office



The main kitchen is in the basement of the building, and is replete with every modern convenience to prepare food. The kitchen is connected with the various floors by a dumb-waiter.



This cheery, homelike six-bed ward is on the first floor. The huge bay window faces south and catches the sun almost all day. The surroundings are planned to make recovery from illness as pleasant as possible.

are on the left side of the main entrance hall.

The second floor is devoted mainly to maternity cases, and contains the finest equipment available. Included on this floor are a nursery, an isolation nursery, a maternity bath, a maternity utility room and a series of well appointed private and ward rooms for maternity patients.

Kitchen Is in the Basement

The third floor is given over to surgery. The facilities include the major and minor operating rooms, a sterilizing room, a surgeons' dressing room, a surgeons' scrub-up room and a work-room. There are also a number of completely furnished private rooms and two-bed and three-bed wards on this floor, but for the present these rooms are being used as nurses' quarters. These rooms provide for quick expansion of the hospital when necessary.

The superintendent's suite, consisting of a bedroom, a living room and a bath, is on the fourth floor.

The basement houses among other things a large modern kitchen. There is a special diet kitchen

for the preparation of diets. A dumb-waiter connects the kitchen with all floors. A pleasant dining room for nurses and a dining room for the other employees are also in the basement. The drug room and autopsy room are near the ambulance entrance. The passenger elevator is convenient to the ambulance entrance.

Heat and hot water are supplied by two oil burning boilers in the sub-basement. Should the electrical power supplied by the electric company give out, emergency storage batteries in the electrical control room provide the necessary power during the lapse of service.

The Aim of the Management

The Harrington Hospital admits and treats all types of patients except those with contagious, mental and chronic diseases.

The aim of the Harrington Memorial Hospital management has been to equip and carry on a hospital fully approved by the American College of Surgeons, recognized by the American Medical Association and a member of the American Hospital Association.

The Forgotten Man as a Hospital Asset

By CHARLES F. NEERGAARD

New York City

IN 1883 William Graham Sumner, professor of political and social science at Yale, delivered his memorable lecture on "The Forgotten Man." This individual was rediscovered in the recent presidential campaign and was used as a political asset. During these difficult times, when hospitals must readjust their affairs if they are to carry on the day's work and safeguard the future, it might be well to appraise the Forgotten Man as a special hospital responsibility.

Professor Sumner, with the dispassionate view of the sociologist, pictures the old clash between human sympathy and political economy, and shows up in high relief a society that provides for the weak and worthless but too often neglects the needs of those who are of real value to the community. In various passages he says, "The pauper and the physically incapacitated are an inevitable charge on society. But the weak, who constantly arouse the pity of humanitarians and philanthropists, are the shiftless . . . the negligent . . . the inefficient, or they are the idle, the intemperate, the extravagant and the vicious. Now the troubles of these persons are constantly forced upon the public attention as if they and their interests deserved special consideration, and a great portion of all organized and unorganized effort for the common welfare consists of attempts to relieve them. I do not wish to be understood as saying that nothing ought to be done for these people by those who are strong and wise. But if you give a loaf to a pauper you cannot give the same loaf to a laborer.

He Asks No Favors

"Now this other man who would have got the loaf but for the charitable sentiment which bestowed it on a worthless member of society is the Forgotten Man. . . . Why should we not have the satisfaction of thinking and caring about clean, honest, industrious, independent, self-supporting men and women who have not inherited much to make life luxurious for them, but who are doing what they can to get on in the world without begging from anybody? Certainly the philanthropists

and sentimentalists have kept our attention for a long time on the nasty, shiftless, criminal, whining, crawling and good-for-nothing people, as if they alone deserved our attention. . . . It may shock you to hear me say it, but when you get over the shock it will do you good to think of it: a drunkard in the gutter is just where he ought to be. . . .

"The Forgotten Man is delving away in patient industry, supporting his family, paying his taxes, casting his vote, supporting the church, the school and the hospital, reading his newspaper, and cheering for the politician of his admiration, but he is the only one for whom there is no provision in the great scramble and the big divide. The Forgotten Man is never a pauper. He almost always has a little capital because it belongs to the character of the man to save something. He is the man who is never thought of, the victim, through neglect, of the reformer, social speculator and philanthropist. We pass him by because he asks no favors and does not appeal to the emotions or excite the sentiments. We do not remember him because he makes no clamor."

Proper Hospital Facilities Are Lacking

This good citizen, when sick, calls in his doctor and if he goes to the hospital, wants moderate priced accommodations and reasonable privacy, where his own doctor can care for him. In other words he is the hospital's semiprivate patient, and pretty generally throughout the hospital field, he is unprovided for—he is the Forgotten Man. Statisticians tell us that of our 125 million people in normal times over three-quarters are of the middle economic class—whether they wear collars of blue denim or white linen. There are a million odd hospital beds in the United States but how many are set aside for this preponderantly large group of customers? There are no countrywide figures to show this, but the proportion is small. For example, in the nonmunicipal hospitals of New York City and Philadelphia but 15 per cent of all beds are designated as semiprivate. In Essex County, New Jersey, a largely residential district, 23 per cent of the beds are semiprivate. What

becomes of all these people when they enter the hospital if there are no semiprivate beds? While some take private rooms and perhaps pay more than they should, the majority will be found in the wards, paying the hospital less than they should—less than the cost of their care.

The generosity of the medical profession in its relations with the hospital and community is seldom properly appreciated by the public at large. Take, for example, the doctors' ward service. It has been an almost universally accepted tradition that if a hospital patient has only a little money the hospital is entitled to priority, and may collect its entire bill before the doctor may charge a fee. In a large majority of the hospitals of the country it has been the rule that no professional fee at all may be charged a patient in a ward bed, irrespective of how much or how little he may pay. Since the depression many hospitals have discontinued this old ruling because the Forgotten Man has become articulate and has been the means of establishing new precedents.

Always Pays His Bills

When he is sent to the hospital he wants to know what it is going to cost him, as he expects to pay his way. The admitting clerk quotes semiprivate rates of from four to six dollars a day, and a list of extras which total ten or fifteen dollars additional. This is more than the man can possibly afford in these hard times. "Have you no cheaper beds?" he asks. "Yes, the ward beds cost only \$3, but you will not be allowed to have your own doctor." "But I want my own doctor." "That is against the rules. However, I will see." An exception is made, then another, and the hospital finds itself with a new classification—the private ward patient—added to its former groups, private, semiprivate, ward pay, ward part-pay and free.

Many hospitals have recognized this new class, some limiting the private ward privilege to the attending staff, others extending it to the courtesy men as well. Wherever this practice has been followed it has soon proved to be a real service, both to the public and the doctors. The private ward patient is no longer an isolated phenomenon. He is here to stay and the hospital field as a whole may well consider him from every angle, particularly the financial. Sumner says, toward the end of his essay, "The Forgotten Man works, he votes, he prays—but he always pays—above all, he pays." He expects to pay his doctor as well as the hospital. He knows nothing of hospital costs and if he is charged \$3 a day for his bed, he takes for granted, if he thinks of it at all, that he is paying in full for what he gets. It is not his fault if the hospital offers him a rate which makes him accept charity.

In hospital parlance the ward patient is actually a charity patient. But the average person who pays the full ward rate probably leaves the hospital in the belief that his receipted bill covers not only his board and lodging and nursing care but some compensation for the house doctor as well. The hospital does not disillusion him.

The community hospital is not a money making institution, neither is it essentially a charity. It exists to care for the sick, irrespective of race, creed, color or cash. It should be so organized and managed that it may give modern scientific care, good food and service, at reasonable rates. It should insist on every patient's paying at least the minimum cost of his care—if he can. It should play fair with its public, all of its public. It is just as wrong to charge patients too little as too much. All of which brings us back to the Forgotten Man, who expects to pay his way, the private ward patient, and his place in the hospital budget.

Semiprivate rates are as a rule based on the average per capita cost. Ward rates are usually determined arbitrarily, by what neighboring hospitals are charging. They bear little if any relation to cost. If the hospital is to play fair with its new private ward patients it should determine accurately certain unit costs. A basic rate should be established, which would cover all items making up the average cost of a day's care in a ward bed. This has been found to range somewhere between 65 cents and \$1 a day below the general average per capita.

How One Hospital Profited

This basic rate should be made known as the least amount that every patient is expected to pay, whether it is collected as a flat covering charge or as a bed rate plus extras. If the patient selects more expensive accommodations, he pays more. If he cannot afford the minimum rate he should be given to understand that he cannot enjoy the privileges of a private patient, but must be entered as a general ward case and treated by the physician or surgeon on service, without charge. This difference between ward private and general ward classifications should be clearly and frankly explained to the public and the patient. One is a private patient and the other a charity case.

The establishment of a basic rate will be valuable to the hospital in many ways. In some states where compensation cases may only be charged the ward rate it would result in a substantial and entirely proper increase in revenue for the care of patients whose full cost should be paid for by the insurance carriers.

What intelligent provision for the care of the Forgotten Man may mean to the hospital's finances

may be readily demonstrated. One teaching institution which sensed the trend arranged to admit ward private patients at a surcharge of \$1 over the regular ward rate. Its collections increased over \$1,000 a month. In several instances the surcharge plan of from 50 cents to \$1 has worked satisfactorily. In two hospitals the trustees accepted the principle of admitting private patients to the wards but failed to appreciate the propriety of increasing their ward charge to cost. These patients could have paid a higher rate, as they paid their doctors a fee, but they were not asked to do so. In one of these hospitals the actual loss was over \$12,000 for the year. In the other, more than half of the work of the hospital was done for private ward patients. The result was disastrous. The average per capita cost was \$6. The basic rate, had they figured it out, would have been about \$5. The charge for ward beds was \$3 a day, which with limited extras brought the average ward receipts up to \$3.75 a day, or a loss of \$1.25 a day on each private ward patient, and there were some 20,000 such days. The hospital had a deficit, of course, but as the city assumed the full responsibility for practically all charity cases, the deficit was traceable entirely to the faulty policy which countenanced bargain rates to private patients. There is a moral angle to this. The trustees not only used endowment income to meet their deficit but solicited donations from the community at large, on the usual plea of providing charity for those who needed it. Such a situation is at least

suggestive of the way in which trust funds have been misused.

Most community hospitals now find it difficult to make ends meet. Fewer of their private rooms are occupied. Contributions have fallen off, dividends have decreased. In many instances the condition is critical. The pay roll has been cut and every possible economy practiced but still the deficit looms large, with no funds in sight to meet it. To suggest the possibility of increasing collections from the patients themselves may sound absurd—but there is the Forgotten Man. Now if ever is the time to remember him. He may not be so easily distinguished as he was in Sumner's day, but he is still with us. If he has a job he will pay. If the times have hit him pretty hard he may have to drop from the semiprivate class and become a ward private patient, but he will pay, not only the hospital but the doctor; he will maintain his self-respect.

We are apt to lose our perspective in times like these. Everyone is not out of work, only one in four. Wages have been cut, but the cost of living has fallen fast. When we get down to fundamentals, a man needs food, lodging and health, and that intangible but invaluable asset, morale. The hospitals are doing their bit. They have much to contribute in helping people to keep their self-respect. Let them get the basic rate down to a minimum. Let them give the Forgotten Man a chance to pay the cost. He should not be forced to accept unwanted charity. Let them give the Forgotten Man his money's worth and he will pay.

A Plan for Promoting Hospital Industries

The various odd jobs about a hospital should be considered as occupational therapy and every foreman and forewoman should be preëminently an occupational therapist, according to Dr. L. Cody Marsh, assistant physician, Worcester State Hospital, Worcester, Mass.

It is necessary in all hospitals to get more patients working more effectively. Every employee who comes in contact with patients shares in the responsibility of helping patients to get well. The mental hospital is a great social industry in which the raw material of unhappy broken lives is transformed into lives whole and happy.

To bring to fruition such a conception requires first of all an industrial survey of the mental hospital. Each patient must be studied and information gathered on his job history, pastimes, hobbies, occupational interests, aptitudes and ambitions.

When a survey has been made and the cards have been indexed, every request for patient employment anywhere in the hospital should be routed through a personnel man. Transfers of patients should also be handled through the personnel office.

A series of classes should be held for all foremen and forewomen who are handling patients in the hospital. These

classes could be conducted by the personnel man, with occasional help from a leader in the community. The latter could instruct the foremen in the technique of producing group spirit. There should also be instruction in psychiatry and the tenets of occupational therapy. Problems could be discussed at these meetings and a general interchange of experiences made in the art of handling patients, getting them to work and arousing their interest.

How to Reduce Elevator Costs

The practice of leaving generator switches turned on in cars taken off the line during low traffic periods is a common source of waste in the operation of elevators.

It is considered poor practice to energize the entire group of cars in preparation for the morning rush, when in fact all cars would not be manned simultaneously, but in periods ranging from ten to thirty minutes. Another expensive practice is to permit supervisory employees to take a car when making an inspection tour of the building and leave the car energized at each floor.

Taking cars out of service between peak periods saves not only power consumption and wear and tear on equipment, but also permits the repair crew to make repairs and adjustments in regular time, thereby avoiding overtime work.

Excerpts From the Study on Medical Education*

A BRIEF glance at the historical development of medical education in this country not only reveals the emergency character of its early history, but also explains some of the present difficulties which have grown out of efforts to correct the deficiencies of the recent past.

Physicians in the early American colonies were usually clergymen for whom medicine was a companion profession, taught as a part of the preparation in England for service in the Church. For more than a century and a half there was no university north of Mexico City in which medicine was taught. Very few students could afford to go abroad to study medicine. From necessity the only method of training physicians was by apprenticeship under practicing doctors and the clergy. The young student attached himself to a preceptor, and by observation, constant companionship and some reading, but chiefly by imitation of his master, learned the art of medical practice. There was no semblance of scientific training in the process.

* * *

Medical education has concerned itself in the past almost exclusively with the training of physicians and with contributions of new knowledge regarding health and disease. The medical needs, in the light of knowledge which existed then, were relatively simple. The social organization was also simple. Leaders in the profession were fully aware of the problems of their day and endeavored to train students in keeping with current knowledge and practice.

The rapid growth in knowledge and the changes in social organization in recent years have greatly complicated the problems of medical service. The rapidity of the change and the more widespread public recognition of the place of health in individual, community and national life have emphasized the importance of securing a more satisfactory distribution and utilization of the trained personnel in relation to the needs and the social organization.

* * *

No difficulty is experienced in demonstrating that physical and mental health is the greatest

asset of a nation as well as of an individual. It is one of the necessities of everyday life. The prosperity and happiness of a people are largely dependent upon mental and physical vigor. Ill health and its effects are recognized widely as one of the major causes of dependency and unemployment. The most pressing health problem is to devise a permanent and comprehensive program of conserving health and treating illness and disability which will become an essential part of the cooperative endeavor known as civilization.

There is general agreement that the greatest health problem in the country at the moment is that of securing an adequate distribution of modern medical services to the entire population at a reasonable cost to the individual and the community. It is clear that present day knowledge of the diagnosis, treatment and prevention of disease is far in advance of its application to the needs. This lag is not the fault of the medical profession but is a characteristic social phenomenon which has always existed. It is accentuated now because of the rapidity with which knowledge has grown in recent years. The gap between what is known and what is utilized cannot be entirely closed, of course, if medical knowledge continues to expand, but it can be narrowed considerably.

* * *

The problem of medical care is exceedingly complex. Before substantial progress can be made toward its solution it will be necessary to secure a reasonably clear definition of the present and probable needs of the immediate future for medical services. These vary considerably in the different sections of the country because of local conditions.

The second step in solving the problem is a determination of the provisions necessary to meet the needs, including the essential facilities such as hospitals and laboratories and the requisite personnel—physicians, dentists, public health officers, nurses, dietitians, laboratory technicians, social service workers and others. It is important that the program designed to meet the situation should be based on practical consideration of available facilities, personnel and resources, and not be presented as either a purely academic speculation or a function necessarily to be performed by the government.

Defects in the methods of medical practice in

*These excerpts are published through the courtesy of Dr. Willard C. Rappleye, director of study, Commission on Medical Education. An editorial on this final report of the commission appeared in the January issue of THE MODERN HOSPITAL. Copies of the report may be obtained from the Columbia University Press at \$2 a copy.

this country are widely recognized, but there are fundamental advantages in the American scheme which ought to be retained and extended. The solution of the problem is not the destruction of the present system and the substitution of a paternalistic plan ill adapted to the philosophy of American life, but rather the evolution of a pattern which will embrace the desirable features of present methods and the correction of their defects.

Educational Features Are Paramount

It is highly important that the facilities suggested should be adapted properly to the needs to be met in each community and that the professional groups be integrated to meet their public responsibilities. The distribution, organization, education, and continuation training of personnel and the effective correlation of facilities and professional workers are requisite to proper functioning of the health program in any area. These several features can be provided satisfactorily only through regional planning by those in possession of the knowledge and resources required to meet this large public problem.

There is some danger that public thinking has been maneuvered into an unfortunate position recently in regard to this whole matter, for emphasis is being placed upon the present organization and cost of medical care, rather than upon the support of an adequate medical service of high quality. Inasmuch as a high quality of medical service can be provided only by trained personnel, the educational features of any program become paramount. They concern themselves not only with the recruitment and training of physicians, nurses, social workers, hospital executives, public health officers, sanitarians, dietitians, physical therapists, laboratory technicians, and others essential to a health service, but also with a program of continuation education which will keep these various professional groups abreast of new knowledge and methods.

Following a reasonably accurate determination of the needs and the facilities and personnel required, the approximate cost of a satisfactory program for a large portion of the population can be calculated.

The methods of meeting the cost can be adapted to the economic status of those receiving the services. There are some families in every community who can pay the full cost of care from current income or savings without serious inconvenience. A large proportion of the population of most communities can pay for the costs of the ordinary illnesses encountered, but many of this group cannot or do not provide for the expensive items of serious illness, hospital care, specialized treatment or prolonged convalescence.

For these expensive items special provisions must be made and already exist in many areas in tax supported or private clinics, hospitals and other community organizations. A third element of the population cannot provide for any form of medical care. The community should, and in many places does, make full provision for them. In such programs physicians everywhere make a large contribution of their time and energy. The methods of providing the financial support by individual payments, by collective payments or by taxation can be left to local determination. There is a considerable experience in this field already in existence.

Owing to the great diversity of local social and economic conditions and the varying degrees of local public opinion regarding sound health policies, no single or artificial program can be imposed upon a given community. The effort must be to educate rather than to legislate. The problems are as yet essentially local and practical, not general and theoretical.

* * *

The time lost because of illness averages between seven and nine days per employed person and represents about 3 per cent of the usual working year. It is estimated that the 36,000,000 wage earners in the country lose about 250,000,000 work days and the 24,000,000 school children lose about 175,000,000 days in school each year from illness. The financial loss to the country as a whole represented by the lost earning power and reduced production totals well over two billion dollars a year, equivalent to one-half the cost of maintaining the national government. The economic features associated with preventable and premature deaths represent a further large sum. The number of work days and the amount of wages lost because of illness, while very large, are far exceeded, however, by casual and enforced idleness from other causes. It has not been possible to keep the healthy people employed fully even in times of prosperity.

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Current medical practice has taken on certain characteristics which resemble those of contemporary industrial life. Considerable emphasis is being placed upon organizations as a means of providing mass production in medical services. Efforts are made to standardize procedures partly as a reflection of methods in the field of industry. These efforts are based in many instances upon the fundamental fallacy that the human being, who is the unit of medical service, can be regarded as a uniform, standardized organism. The contrary is known to be the case inasmuch as no two individuals are alike, and no two even with the same disorder react in exactly the same way.

Sound medical practice requires careful study of the health needs of each individual—physical, psychic and social.

* * *

The lowered birth rate, the better control and treatment of the diseases of childhood and reduced immigration¹ promise to modify considerably the age composition of the population of the future. In 1860 approximately 9 per cent of the population was fifty years of age or over. At present the proportion is above 16 per cent. If the present control of the fatal diseases of childhood and vigilance in organized public health efforts are maintained, it will be over 25 per cent in 1975. The problems of health and medical practice of the future will increasingly be those of adulthood and old age, rather than those of childhood. This will mean a further increase in the degenerative and chronic diseases, such as cancer and the diseases of the heart, blood vessels, brain and kidneys. These diseases now cause 60 per cent of deaths in persons over forty years of age. The remarkable increase in the average length of life during the last fifty years, to which so much publicity has been given, has been due almost entirely to the control of the diseases of childhood. The mortality rate among children under five years of age has been reduced over 60 per cent since 1900. Life expectancy after adulthood has increased only moderately during the last fifty years.

* * *

There are many factors influencing the various efforts to provide medical care for the people of this country. The expansion of our ideas of what constitutes adequate care, and efforts to provide it for the entire population are among the most important. More advance has been made in scientific knowledge in the last sixty years than during the preceding twenty centuries. The growth of knowledge has been so rapid that time has not permitted its full dissemination in the medical profession, particularly to an extent that gives the individual physician a critical judgment of the value of some of the newer methods which are used or advocated.

The people, vaguely aware of this knowledge, naturally desire to have it made available to them without realizing that much of it is highly technical, costly and of real value only in specific instances. There is a general desire that all practical phases of medical knowledge be within reach of everyone, although the public is not prepared to provide all the necessary resources. Individuals who have an unusual amount of illness are often unable to pay for complete medical care because

the infrequent and expensive items cannot be provided for in the daily budgets of most families. The public, either through private philanthropy or tax supported agencies, now provides such services for many who cannot pay. Even for the ordinary illnesses, however, very few families make provisions in advance, but expect to pay for their care after they recover.

* * *

There is still much mysticism about illness and at least some remnants of the earlier concepts of disease remain. In the Middle Ages the invalid was one peculiarly blessed because he gave opportunity to others to practice Christian grace. The fear of disease, the idea that it is punishment for sins committed, the concept of social inferiority, and the resentment which most people feel toward the inconveniences, worries and financial demands incidental to sickness and for which they do not feel responsible make difficult a rational approach to these risks of everyday living. In recent years, however, an appreciation of the fact that health problems are part and parcel of everyday life has directed attention toward making community provisions for meeting those serious and costly illnesses and emergencies which the individual cannot anticipate. Society is assuming the obligation of providing the means of restoring the sick individual to normal health when he is unable to do so.

* * *

There is necessity for a clearer conception by the profession as well as by the public of the different needs of individual patients, and a willingness on the part of the latter to pay adequately for a basic nonspecialized medical service, which often is far more important and valuable than the services of specialists. This is particularly true in matters of early diagnosis, treatment and prevention, although such a basic service is frequently less obvious to the patient. A concentration of the medical profession and the public upon a medical service aimed at the early diagnosis, treatment and prevention of disease would be a fundamental readjustment in the health program which, in the long run, would be beneficial to everyone concerned and would lower the cost of medical care through the prevention of illnesses that are likely to produce disability.

Some plan to meet our medical needs will be worked out, possibly on a basis which will be suited to the institutions, state of public opinion and conditions found here. As in most forms of social legislation, we shall probably have to go through the long and difficult process of public education. Efforts to solve the problem in local areas have been initiated and should serve as demonstrations for

¹Arrivals: 1,387,318 in 1913; 43,223 in 1931.

the public and the profession. It is to be hoped that the experiences abroad and the mistakes made in the earlier efforts can be avoided in this country. The uncertainties in the situation, as mentioned earlier, are linked with the close identification of all such social legislation with political institutions, a fact which makes the development of a governmentally supervised plan in this country particularly unpromising at present. If sickness insurance ultimately becomes a reality, perhaps we may have the wisdom to set it up under an organization created for the specific purpose and made up of nonpolitical appointees, somewhat like the boards of regents of the state universities and other governmental bodies.

* * *

There is need for the coordination of various professional groups and facilities in each community for the modern practice of medicine in order to obviate the inadequacies of individual efforts, and to secure collective expressions of policy and the active participation of all the professional groups in the joint responsibilities. The hospital represents the common ground upon which the patient, the community and the professional groups meet; it provides many of the specialized and expensive facilities needed for modern medi-

cal care; it embodies the general type of professional and lay organization which, with proper amplification, can best meet the problems presented; it occupies a strategic position in the community to coordinate the various professional, social and economic activities dealing with sickness, the training of physicians and other health workers, and the education of the local community in health matters. It is particularly adapted to the centralization of medical, health and educational activities in rural communities where the population is scattered, the number of persons needing specialized facilities is small, resources are limited and the necessity of providing inducements which will attract well trained physicians, dentists, nurses and other workers is pressing.

It is likely that present methods of employing physicians for the care of the sick in hospitals and public clinics will be modified. The care of indigent patients, long considered the responsibility of the physician, is coming to be regarded as a proper charge against the community. Doctors should be compensated for their work in caring for the indigent sick, although their employment by hospitals or the community is likely to bring about a modification of the completely independent status which they enjoy at the present time.

A Health Service Hospital for University Students

A students' health service was organized twelve years ago at the University of Minnesota in recognition of the university's responsibility to safeguard the thousands of students who are enrolled at the institution each year. An interesting feature of the service is the hospital care that is provided students, which is described by Dr. Harold S. Diehl, director of the service, in a recent bulletin of the Hennepin County Medical Society.

Every student at the university is eligible for admittance to the Health Service Hospital, but the policy is to advise students who have family physicians to place themselves under their care. Students living in dormitories or rooming houses are usually admitted direct to the Health Service Hospital, but if the illness seems serious or if an operation becomes necessary, the student is urged to communicate with his family or his family physician so that arrangements can be made to have this specialized service performed in one of the private hospitals in the city.

No Special Health Fee

This hospital service, or it might better be called infirmary service, because, under ordinary conditions, very few of these students would be sent to a hospital, is of the greatest importance to students who are away from home.

The pharmacy, x-ray and dental departments of the health service are operated on a self-supporting basis, fees being charged for the services rendered. The purpose of these departments is to provide such diagnostic, corrective

and therapeutic services as are necessary to safeguard or improve the health of students.

The entire operating budget of the health service comes from the students. Approximately two-thirds of the total budget is allocated to the health service from the incidental fees that students pay. There is no special health fee. The remainder of the operating budget accrues from certain fees that are collected for individual services, such as x-ray, dentistry, drugs, glasses, use of the operating room and board and laundry in the hospital after two days. No charges are made for professional services rendered by members of the staff.

Intern Selection by Hospitals in Philadelphia

Members of the Hospital Association of Philadelphia have adopted a new cooperative plan for the selection of interns. Honor medical students wishing to apply for internship in these hospitals must supply to a central intern committee, of which John N. Hatfield, superintendent, Pennsylvania Hospital, is chairman, a list of hospitals to which they would like to be assigned, indicating their preferences. The committee will go over the entire list and will then make assignments.

The hospitals participating in this plan will be the following: Pennsylvania, Graduate, Methodist, Jefferson, University of Pennsylvania, Mount Sinai, Temple University, Chestnut Hill, Lankenau, Germantown, Northwestern and Northern Liberties.

How to Benefit From Statewide Publicity

By HARRY STANLEY

Publicity Director, Hospital Association of Pennsylvania, Philadelphia.

IN SEVERAL years' contact with hospitals I have been repeatedly impressed with the fact that they are thoroughly misunderstood, in every town and city. Only a few appreciate their true rôle of caring for the sick or injured.

This seems strange considering how long hospitals have existed. Maybe that's why they are misunderstood—because they are so completely part of their communities that everyone takes them for granted, pays no attention to their problems, expects them to weather any storm and abuses them roundly for every fancied grievance.

If an industry found after years of effort that it had failed to win its market, would it voice a grievance against that market or would it change its selling methods? It would change its selling methods, and here is a lesson for hospitals.

Facts That Are Ignored

I am aware that many hospitals stand well with their communities, but there are others giving equally good care that remain unappreciated. I am aware, too, that such terms as "selling" or "advertising" or "publicity" grate upon the ethical nerves of a great many hospital people—and I can sympathize with them. But the thing they ignore—those hospitals that feel they stand so well—is that they still lack sufficient public support to maintain themselves and still give to those who need it the free care that is to most of us the very heart of the hospital. What others forget—those who recoil at the very mention of advertising or publicity—is that hospitals and medical men have been getting advertising or publicity (call it what you will) for generations. Through the patients they have served, through the persons they have interested, through the building campaigns they have carried on, through the personal contacts they have established, they have been getting publicity, year after year—good or bad.

Of course, they have been issuing reports from time to time—monthly, through the newspapers; in printed form, once a year or so. And some people have read them. Some may even have understood them, if they happened to be on the staff or the

board. But what do figures of income and expense mean, what does the expression "free days" convey, what does the number of pathological examinations indicate to the man who doesn't see the hospital, compared to the human drama going on day and night within its walls? It may be justifiable to say, "There's our story. If you don't grasp it, it isn't our fault." I strongly doubt it.

Meanwhile, what are hospitals doing within the hospital to show their patients, before they return to the everyday world, what hospitalization means?

I still believe this to be one of the hospital's greatest opportunities. I give it top position among all types of educational publicity for hospitals, because the convalescent is avid for information, curious as to what is going on and for the moment completely divorced from that swirl which swallows him up later. It may be argued that good hospital care should speak for itself. But it doesn't seem to—otherwise, hospitals would never be in need of friends or understanding. Hospitals have a wonderful chance to win friends but how few really use it.

Who Is Wrong? Who Is Right?

I suppose hospital people lose their perspective just as easily as other human beings do. They are immersed in their jobs and forget the other fellow's point of view. Of course, he seldom gets theirs—so they are miles apart. Hospitals set up a system and expect the world to conform to it. But the world won't conform; it will bend them first. Meanwhile, just because they are immersed in their work, they grow to think of patients as cases, and wonder why people persist in speaking harshly of hospitals. They resent the interest of the newspapers in what seems to hospital administrators of no importance.

Who is wrong? Who is right? What difference does it make? All life is a matter of delicate personal adjustment. Hospitals belong to the community. The newspapers, as voices of that community can do hospitals a lot of good—or a lot of harm. Apparently they cannot evade publicity

of some sort, verbal or written. At least, they seldom have evaded it. Then, if they can't shun publicity, why not shape it?

After all, how can the hospitals be sure that they know what is trivial or important to the public? I have seen some trivial things lead to a surprising opportunity for education. I have seen some important pronouncements fall absolutely flat as news. The hospitals might get part of their story into print in their own way if they bought paid space and filled it. But how can they be sure anyone would read it? How could they pay for it? Being community organizations, what justification could they find for such an expenditure?

Newspapers Are Willing to Help

As community organizations, the news columns of the papers are open to hospitals at all times. They are the record of moving events. There their story will be read and absorbed. They must dramatize their story, to make it news—but that is not so difficult as some think. Newspapers are willing to help if hospitals will only meet them halfway, will be frank with them, will trust them, will get away from the obsession that this can't be done and that mustn't be said, will realize that the newspapers and the hospitals are part of the same community, and that the major objective is to run a good hospital—and keep it going.

Big things seldom create friction. It is the little things that cause trouble. Newspapers don't understand hospital problems and hospitals don't understand theirs. The newspaper wants the names of the injured before the ambulance discharges its cargo, and the hospital's sole thought—properly enough—is for the victims. But the night supervisor doesn't need to hang up on the reporters; they are sometimes human. She might explain that the facts will be available in a few minutes and save a lot of friction. At the other end of the wire they are probably going to press with the next edition; naturally, they're impatient. That is a drama in a different world that the hospital can't always see.

I admit that I am, at heart, a dyed-in-the-wool newspaper man. That is something you can't lose, no matter how many layers of dignity you superimpose. Therefore, you can discount everything I say, if you wish, on the substantial ground that I am not a hospital man. I am not a hospital man. I am quite sure that I do not subscribe to the views of all the hospital people I know. If I did I doubt whether I could interest either the newspapers or the public in hospitals. So while you may dismiss everything I say because I am not a hospital man, I hope you will regard it as sincerely spoken by one who has been reporter, city editor, and man-

aging editor of newspapers, who has repeatedly seen the hospital picture from that angle.

Frequently, during the years when I was helping to raise money for hospitals, editors used to say to me: "Oh, yes! When you need some money, you come around to see us. But it's a different story when we want anything!"

Then they would proceed to tell me, angrily or bitterly or coldly, according to their temperaments, the pet grievances they held against this or that hospital or against all hospitals. They usually ran the stories because they realized that essentially the hospital was doing a good job and deserved support. Nevertheless, I could not remove their personal prejudices. And the fact that they lent their help never quite satisfied me. So I say that hospitals ought to be able to win them over personally, as well as officially. If they can't there must be something wrong with them—or with the hospitals.

When I was a reporter, I and those I worked with grew to depend for news on certain definite sources. Of course there were the police, the fire department, the hospitals, the district attorney, the marriage license bureau and so on. But we had built up another circle of friends, an informal group of assorted men and women whom we knew as "regular." They were our friends. They would help us in a pinch. They would help get a story or tip us off to one or tell us whom to call. And we were their friends. Suppose one of them had been a hospital superintendent! Suppose he had said, some day, to one of us: "Say, we're planning such and such a step at our hospital. I wish you'd send a man to write it up." Or suppose he had said: "I wish you'd play up what we're doing in our clinics." Do you think we'd have turned him down? Now, why shouldn't newspapers number among their real friends hospital superintendents—just as they do insurance men, brokers, lawyers, ministers, educators and business men?

Don't Be Afraid to Upset Routine

A story detrimental to some hospital often breaks late at night, and appears at the breakfast table without the hospital's side of the story. A second day correction is useless. You can never catch up with a lie or an inaccuracy. The damage is done and may be lasting. But I cannot imagine a reputable newspaper man failing to give the hospital a chance to refute the story, unless he did not know the superintendent and did not care what he thought, or had some reason for taking a shot at the institution, on special or general grounds.

Most of us who have one-track minds (and I am one) hate to stop whatever we happen to be doing at the moment. Picture me, struggling with a re-

lease for 140 dailies of the state, forced to stop in the middle of my labors because some feature writer who has left her notes at home wants to know whether our directress of nurses has gray eyes and brown hair! How do you react to unforeseen requests from the callous press? Do you try to come halfway, or do you slam the door? Do you try to find a way, or do you squelch the offender by saying brusquely that it can't be done? If your routine is so fixed that it cannot be disturbed, you are entirely too institutional. How can you expect sympathetic treatment next week, when you need a story? I call it stupid to neglect what may really be an opportunity, just because it upsets routine.

What Makes News?

Of hospital publicity, so called, there is an abundance. But a great deal of it is meaningless or of little value to hospitals. Why? Because it carries the flash of the news, but fails utterly to bring home some of the points that the hospitals consider of interest. Why not try to have those points incorporated while the story is news? Why waste a moment regretting the imperfection of the story? A series of photos of twins or triplets is good, but holds more meaning for the public when it learns that so many sets of twins were born in the past year or six months, or how large a proportion of births were in free beds. Reporters will not ask you about that because it will not occur to them. But you can tell them—and it will add point to the story, disarm some critics and win some friends.

You may call this a detail. It is not a detail. It is fundamental. It imparts a sense of direction to the publicity emanating from your hospital. It builds up the picture you want the public to have. You wonder that they don't have it. You yourselves have admitted they don't.

What makes news? Where is it most likely to spring from? I wish I knew. There have been attempts at definitions, but they all fail. Someone once coined this expression: "If a dog bites a man, that's not news; but if a man bites a dog—that's news." For years the definition so aptly put has been bandied around, no one, however, expecting ever to see a human being bite a dog. But the other day this item appeared in the papers: "Two-year-old Johnny Willoughby was bitten today by his small puppy. So Johnny bit the puppy!"

The trivial things are often the ones that make most interesting reading, the things that permit us to bring home the points we want to make. You can make the activities of your hospital interesting. There is no law compelling you to be ponderous or profound. Lincoln knew how to illustrate his point with an anecdote. A reporter strolling into

a police station may be told that nothing has happened, and that may be true; yet that same reporter, lounging in the station house for half an hour, can find innumerable stories just from listening to the people who come in with complaints.

You may ask, "How am I to find these stories? I'm a hospital man." Isn't the real difficulty your unwillingness to see news in the trivial?

You may well say, "But what about the really important things we're doing? You can't tell them lightly. They must be accurate and that takes explanation." I agree with you. I think the way important developments in hospital work and in medicine are handled is a crime against accuracy, an insult to intelligence. But hospitals are to blame if they can't make them seem real to writers who ask for information. There is a great opportunity for the hospital man who will take the pains to reduce complex procedures to simple outlines which the lay mind can absorb. Therein lies the highest type of education, because the complex subject grows interesting and it will be read and retained.

Shall I tell you the underlying thought behind the educational movement initiated by the Hospital Association of Pennsylvania several months ago?

Our idea was that of a shifting flashlight, illuminating the dark spots least known or understood. We are not trying to tell our story all at once. We could, I suppose, if we could afford to print it, or if anybody would read it. We might issue our story in sections, in big volumes, and say: "Here's the dope on compensation insurance; here's what it costs for private room care; here's our story on state aid; here's the truth about accidents." And then we might add: "Now, if you don't read these, it's your hard luck."

Will Not Interfere With Local Publicity

We are not attempting that because we realize that the man in his home and his family are interested in a great many other things, chiefly themselves. They are trying to follow the movies, sports, the theaters, books, plays, concerts, operas, and only now and then are they at all interested in the problems of a hospital.

But one out of every ten persons inevitably arrives at a hospital. They ought to know a little more about hospitals than they have hitherto. Just a little more. We can't expect them to grasp the whole story. But that little will help if they pause before condemning, if they take the trouble to disarm thoughtless criticism, if it induces them to give or bequeath money to hospitals later on.

It is not our thought to replace anything that is being done now by the different hospitals. But it is our hope to give greater depth and a truer sense

of direction to hospital publicity. It is hard for the newspaper reader in a single town to get the real perspective as to the usefulness of hospitals in his own community unless we show him what is happening in other hospitals. It would be silly to compete with local hospital publicity or to attempt to replace or curtail it in any way. The more intelligently it is handled, the better for all hospitals in the district. But we can, speaking for the majority of hospitals, give those stories added meaning, broader scope, greater depth. We can try to make people think. If some of the most pressing problems facing hospitals today are to be solved, more than just a few people will have to think intelligently about hospitals.

As I see it, it is within the association's province to deal informatively and interestingly with every basic or minor phase touching the operation of a hospital—dietetics, housekeeping, maintenance, engineering, purchasing, nursing, administration, clinics, surgery, x-ray, laboratories. Why not? There is a story—perhaps there are many stories—in every one, if you try to look at them with new eyes. And I think they can be interestingly told, without venturing improperly into the field of medicine. We shall attempt in no way to impart medical information, but we do feel that hospitals can go further than they do in health education. They can certainly clarify medical achievements and do the medical profession which is so closely linked with their destinies a distinct service by educating people not to chase will-o'-the-wisps in search of health.

Have Barely Scratched the Surface

The growing popularity of health columns in newspapers today is proof that the people are hungry for accurate guidance and do not know where to turn. Is it any wonder that they follow fads to their ruin and become the victims of the unscrupulous?

In beginning the work for the association, my fundamental thought was that a practical syndication of ideas offered the hospitals a thorough and economical way of presenting their problems to the public of the state. Ideas that needed to be adapted, could be adapted. I am not referring to newspapers alone, but to folders, leaflets, radio and other forms of publicity. For I believe that we have barely scratched the surface of the opportunities for real education of the public. The printed word is particularly effective. I see no reason why the association should not produce material and make it available to all hospitals of the state, on a pro rata basis of cost depending on what they used, thereby saving in the cost of preparing that material.

I am not merely discussing plans when I mention these things. I am discussing projects that have already proceeded far, and await only the evidence of your interest and support. There is little use in doing them unless you are interested.

As long ago as last August, in a memorandum to the association's publicity committee, I said: "If such a plan were to be carried on without the active cooperation of a single hospital, it would still be possible to get some beneficial results. But I feel that each hospital has a direct stake in clarifying hospital problems and winning new friends and that, with its whole-hearted cooperation, many times the benefits can be assured."

United Support Is Needed

That was last August and this is March. What I said then still holds good. Frankly, I do not want to undertake to produce anything for the hospitals of this state that they are unwilling to use. I am not eager to offer any guidance that they are unwilling to accept. You will pardon me for adding that I see no reason why hospital people—the very ones who wonder why patients won't follow their doctor's orders—refuse to follow suggestions in a field which they admit is foreign to their own. I confess that I am less interested in the financial support of this program than in the spirit of cooperation given.

We want the support of every hospital in this movement which has been undertaken for every hospital. But we want them to enter into the spirit of the project.

With the national hospital group beginning educational work on a broad scale, with local institutions making themselves more secure in their own communities, the work of the association can tie these together and deal effectively with problems peculiar to this state.¹

Admissibility of Hospital Records and Charts as Evidence

In a will contest, the plaintiff complained that she was the common law wife of the decedent. Over her objection, the trial court admitted in evidence certain charts and records of a hospital in which he had been a patient, in which he was described as a single man. This information was based on statements made by the decedent to hospital attendants. These charts and records, the Supreme Court of Minnesota held, were hearsay, self-serving and inadmissible although there may be cases in which the circumstances are such as to make statements so recorded admissible as a part of the *res gestae*. (*Ghelin versus Johnson* (Minn.) 243 N. W. 443.)

¹Paper read at the meeting of Hospital Association of Pennsylvania, Philadelphia, March, 1933.

New York City Studies Performance of Different Oxygen Tents

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THE therapeutic effects of oxygen administration by means of tents have been lauded by some competent observers and questioned by others. A certain amount of the prejudice against the use of tents may be attributed to the discouraging outcome that results because most of the patients treated are moribund before oxygen is ordered. However, the use of the oxygen tent has hitherto been limited largely because of defects in the apparatus itself, or because of faulty methods of manipulation.

Selection of Suitable Tent Is Important

The oxygen tent is a small and specialized air conditioning machine which must not only supply oxygen in adequate concentration, but must also provide for the elimination of carbon dioxide, moisture, heat and body odors, and for the proper regulation of air currents. A good tent, when properly operated, will maintain proper high concentrations of oxygen with otherwise desirable atmospheric conditions. An inefficient tent, or a tent unskillfully handled may on the one hand provide insufficient oxygen for relief of the anoxemia, or it may, while relieving the anoxemia, superimpose conditions favorable to heat exhaustion. On the other hand, it may permit toxic concentrations of oxygen or excessive concentration of carbon dioxide. The selection of a suitable tent is thus a matter of prime importance for effective oxygen treatment. Although a number of types and makes of tents are at present commercially available, a critical study has not been made heretofore of their performance under laboratory and clinical conditions, nor have specific performance standards been established. A comparative study of different oxygen tents was deemed worth while as an aid to the clinician and to the hospital executive, and was accordingly undertaken by the department of hospitals, New York City.

Early in the study it became apparent that although the oxygen tent represents an application of air conditioning principles, many of the prob-

lems involved in the design and operation of oxygen tents have not come within the experience of ventilating engineers. Among the special features involved are the diminutive space to be conditioned, the special closed ventilation system involving low leakage rates, the control of oxygen and carbon dioxide concentrations, and the precautions required in connection with the fire hazard. As a basis for the selection and standardization of tents, for the rating of performance and the direction of manipulation, it was necessary to study the factors affecting atmospheric conditions in tents. In this study we were aided by the equipment of both the Littauer Pneumonia Research Fund of New York University and the Harlem Hospital, New York City. The equipment included an oxygen chamber and a quasi-continuous oxygen and carbon dioxide recorder, various tents and accurate meteorologic instruments. The research work received financial support from the Chemical Foundation, Inc., and from an anonymous donor.

Besides studying the performance of various tents in the laboratory we had an extensive experience in the use of different kinds of tents on the ward. Accurate measurements of the conditions maintained in practice were recorded.

Some Current Theories Upset

Our study has led us to reject as untrue the following current beliefs:

1. That there is an important loss of carbon dioxide by diffusion through rubber fabric, or by solution in water condensate or in ice melt.
2. That most of the air leakage occurs from the canopy and that the leaks from the conditioning unit are insignificant.
3. That serious leaks will not be present in a new tent.
4. That the oxygen concentration in tents is conditioned largely by the flow rate of oxygen and that the oxygen concentration can be predicted from the oxygen feed without reference to variations in leakage rates. In this connection we consider that

tents are misbranded if the oxygen concentration supposedly attainable at definite flow rates is specified by the manufacturer, unless it is clearly stated that these concentrations represent test conditions with or without a patient at the time of purchase or at some other specified recent date.

5. That small tents are much more economical to maintain in respect to oxygen than larger and roomier tents which fit comfortably about the patient and permit him to move without disturbing the base of the canopy.

Four Types of Tents Studied

Oxygen tent specifications have been adopted that are based upon a digest of the study, with due regard for the clinical requirements for adult patients as well as for children and infants.

The specifications were written with a view to sturdy design and economy of operation in oxygen, soda lime, refrigeration and electricity, as well as to safety in respect to fire and gas concentrations. Ready and inexpensive replacement of destructible portions was considered desirable. At the request of two leading manufacturers of motorless tents, specifications were not made less lenient for these tents, although none of the motorless tents at present available meets the specifications in respect to atmospheric conditions to be maintained.

The electrical specifications were written with a view to maximum safety.

Two types of motorless oxygen tents and two types of motor blower tents are available.

One type of motorless tent, the hood tent, does not have a cooler or carbon dioxide absorbent and has no device for vapor circulation other than the incoming oxygen. Because of the rise in the temperature of the contained air and its saturation with moisture after short periods of use this type of tent is ill tolerated, especially by febrile patients. It is not suitable for the treatment of patients with pneumonia or heart disease.

The second type of motorless tent relies on the pressure in the oxygen tank to produce air circulation, and is provided with a cooler or with a cold bunker to induce convection currents, which may assist the air circulation. This type of tent may also include a device for eliminating carbon dioxide. The oxygen pump may be either an injector or a piston operated bellows. The oxygen pressure may also be used to rotate or to wave a fan. With the exception of a modified mine safety appliance tent this type of machine, in our experience, has not been satisfactory in respect to atmospheric control. Its apparent simplicity and relative freedom from electric fire hazards are offset by a number of disadvantages arising from the fact that air circulation and oxygen concentration are both

controlled by the oxygen flow rate. If the oxygen flow is increased to improve the air movement and to lower the temperature by drawing more air through the cooler, the oxygen concentration may rise to dangerous toxic levels. If on the other hand the oxygen flow is reduced to give the proper concentration, the temperature control may be inadequate. If the oxygen cylinder should become exhausted unnoticed by the attendant, a hazardous situation may develop. Cessation of the oxygen flow will not only allow the concentration to fall, but will cut off air circulation, thereby inducing intolerable temperature conditions. At the same time, the air leakage rate may become so low in the absence of forced drafts that if the tank is not replaced within one or two hours the oxygen concentration may fall considerably below its normal value in the room air. The use of a cold bunker without additional means of air circulation has not been satisfactory.

In the motor blower type of tent air circulation and oxygen concentration are independent. The motor may be operated by electricity or by running water. Motor blower tents may be classified as (1) those having an air cooling ice chest and (2) those having a heat interchanger.

In the first type of motor blower tent the air circulates in direct contact with ice. This type of cooler is mechanically simple but has a number of disadvantages. The cooling depends to a considerable extent on the size of the ice chunks, and the cooling may become inefficient if the ice becomes channeled. The drains may become clogged and the ice melt may then shut off free air circulation. Conditioned air rich in oxygen is lost whenever it is necessary to replenish the ice chest with ice, broken to size. Unless the air circulation is stopped during the reicing process, conditioned air is lost from the canopy as well as from the cooler. The last mentioned disadvantage may be overcome by providing twin ice chambers with cut-off valves.

No Oxygen Loss in Icing Process

In the second type of motor blower tent the air is cooled by passing through a heat interchanger that is supplied with circulating ice water. These tents have the disadvantage inherent in circulating water of possible leaks in the water line. They have the advantage of uninterrupted air circulation without loss of air or oxygen when ice is added. The ice need not be broken since the size of the ice blocks in the water cooler does not greatly affect the air temperature. Dry ice, provided it is properly vented to the outside, can be used to cool the circulating water or the air.¹

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*The Hospital and the Medical Staff:**

Fever Therapy—Some Striking Results Achieved Thereby

By WILLIAM H. SCHMIDT, M.D.

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MANY great achievements in modern medicine are really not discoveries but are the result of the investigations of empiric practices dating back to ancient days. When viewed in the light of modern knowledge it is often found that these practices have a sound scientific foundation. Clinical experience frequently leads to the discovery of underlying causes and no doubt much of great value still remains hidden in the activities of the founders of medicine.

The value of hot springs was recognized and utilized by the ancients as far back as history goes and even the Japanese centuries ago, although not knowingly, elevated body temperature in this manner. The fame of these curative springs was such that it has survived to the present time.

The Early Experiments

Wagner-Juregg, a Viennese, was the first modern physician who gave this subject serious thought. An experience as far back as 1880 directed his attention to the subject. A woman afflicted with mental illness developed a severe case of typhoid. She recovered and with recovery came sanity.

Such a miracle developed his interest in its cause. Other similar cases occurred following recovery from diseases accompanied by a high fever, such as pneumonia, typhoid fever, erysipelas and malaria. The idea then came to him that to inject malaria germs into the bodies of these hopeless cases might cure them. But his idea was so revolutionary that it received little support and much condemnation. So for ten years he experimented in his own asylum with various methods of developing fever. It was not until 1917 that Wagner-Juregg inoculated his first patient with malaria. From then on progress was rapid and the method was perfected so that it soon became the accepted treatment for paresis, one of the most common forms of mental disease.

The theory had now been proved but the method was faulty. The patient was given a new disease which of itself carried a mortality in some instances as high as 10 per cent. Some patients were immune to malaria. Others were so seriously ill that it was necessary to check the malaria to save the patient's life before the fever had a chance to produce its beneficial effects. We were dealing with a curative agent which we could not control and which might have a good or bad effect.

The successes led to a search for safer means of producing fever. Wagner-Juregg had tried tuberculin when it was first introduced and as knowledge increased typhoid toxins were tried, followed by rat-bite fever and nonspecific protein therapy. All of these methods were attended with a certain measure of success but toxic substances were being put into the body, which increased the load to be borne by an already overburdened organism. There was still something to be desired.

It was realized that the ideal was some means of producing fever that would be under the control of the physician, both as to the degree of temperature and the length of time the temperature would remain elevated and at the same time would be devoid of the dangers produced when toxic substances are injected into the body.

Some Later Developments

In recent years there has been introduced to the profession the use of the high frequency current in the treatment of various localized conditions. This is popularly known as diathermy and its effect is simply the production of localized heat by the resistance the tissue offers to the passage of the current. The body, having an efficient heat regulating mechanism, any localized heat is quickly dispersed and equalized by a marked increase of circulation so that the effect remains localized. Still it was realized that a large amount of heat could be produced in the body without harmful effects. Neyman conceived the idea of using large electrodes to permit the introduction of a great amount of heat and, by wrapping the patient in

*This article is one of a series of discussions for the purpose of ensuring better team work in the hospital through a fuller understanding of the interrelated problems of the medical staff and the administration. The first article of the series appeared in the January issue.

blankets, radiation of heat was prevented, resulting in an elevation of the patient's temperature. Cocke and Kink, about the same time, using a machine of large capacity, were able to elevate the temperature of the patient within an hour or two as high as 105° F.

Here at last was a method of producing an aseptic temperature which could be controlled at will both as to height and duration as well as to the frequency of treatments. Some difficulties developed. The patient was decidedly uncomfortable being so tightly wrapped in blankets that he could not move. Electrical burns occasionally developed especially when the method was used by the inexperienced or with faulty technique.

About this time Whitney, an engineer, developed another electrical method of producing fever which did not require the use of electrodes in contact with the patient's body. He found that the energy radiated from a radio broadcasting tube of 12-meter wave length produced an elevation of temperature in persons subjected to its influence. This effect was concentrated by radiating the energy from one condenser plate to another, the patient being placed between them. This resulted in a rapid rise of temperature, although the patient was not wrapped in blankets and was not in contact with the electrodes. It was found that if perspiration collected on the body, arcing resulted, with consequent burns. This has been overcome by improvement in technique. One drawback is the expense of the apparatus.

Good Results Have Been Secured

A more simple form of producing fever is the use of an apparatus which consists of an airtight cabinet, heated by an infra-red element, and with proper humidity maintained in the cabinet. The patient rests on a couch, has no electrodes in contact with his body and the head protrudes through a diaphragm at the upper end and is outside the cabinet. In this way the patient can move about, not being restrained, and hence is more comfortable. This apparatus elevates the temperature to 104° F. in about an hour and has an automatic control.

There are therefore several ways of producing an aseptic controlled fever and eventually that method which produces fever quickly and with the least discomfort to the patient will become the accepted form of treatment. Improvements will develop and it may be that new and better methods may yet be discovered.

Diseases may be grouped into two classes, (1) self-limiting diseases, such as typhoid, pneumonia, diphtheria, in which the patient becomes infected, develops fever and either gets well or dies in a

short time; (2) diseases, many of them due to germ infection, in which the patient does not develop fever and neither gets well nor dies.

The outstanding example of this is syphilis, a germ infection which does not excite a body reaction and which continues to exist actively in the body for years until it eventually produces grave changes and far-reaching effects. This is the disease, in its mental manifestations, in which Wagner-Jouregg had his best results and the use of the electrical methods show that these results can be duplicated. In the hands of experienced men both the malaria method and the electrical method produce about 30 per cent of complete remissions in paresis.

It seems likely that it will be possible to achieve similar results in the treatment of multiple sclerosis. At the Jefferson Hospital, Philadelphia, nearly 100 cases of this serious disease have been treated with encouraging results and in many instances complete remissions have occurred. Definite statements cannot be made as time only will tell whether a permanent cure has been effected.

Postencephalitis with Parkinson's syndrome, another mystifying and hopeless disease, has also shown some startling improvements. Encouraging results have been reported in chronic arthritis, asthma and other obscure affections.

This is a new form of therapy and its indications or limitations are far from definite. It is difficult to predict what the future has in store.

Its greatest field of usefulness will be in hospitals where the chronic sufferer and the mentally ill are treated. The treatments are time consuming and expensive but when we consider the economic saving that results with the discharge of an otherwise chronic patient, it can be seen that the procedure is well worth while.

The field for future investigation is fascinating and unlimited and if no more is accomplished than has been at this date, there has undoubtedly been added to the physician's armamentarium an efficient and successful method of treatment for a number of otherwise hopeless diseases.

Schools Closed by Hospitals

Approximately 110 hospital schools of nursing have closed since January 1, 1931. A few new schools have opened but the exact number is not known. There are now approximately 1,692 schools meeting the minimum requirements set by law in the various states.

Arkansas leads the states in the number of schools reported discontinued, with nine closures during the period mentioned. Eight schools in Iowa and the same number in Texas have closed; seven in Alabama and six in Georgia. Thirty-four states and the District of Columbia are represented in the list of closures.

Practical Administrative Problems:

The Patient Looks at His Hospital Bill

THE composite bill of indebtedness that the patient receives at the end of each week of hospital treatment or upon his discharge is often one that strikes terror to his very soul. To say that he is surprised at some of the items included therein would be to state the case mildly.

At some time prior to admission he may have been rather generally, yet hurriedly, apprised of the items for which he will be charged during his hospital treatment. This is the rule, but unfortunately there are many exceptions. If the patient has been suddenly and seriously taken ill, in the excitement of endeavoring to save life, both the physician and the family may have been led to overlook the practical aspect of the cost of institutional treatment. Moreover, frequently the patient may have been led to believe that the charge for the hospital room would cover all laboratory and other specialty charges.

Too often the patient receives from the physician no estimate of the expense for professional services. This is particularly true in the case of semi-private patients who are led to believe or choose to believe that the hospital charge includes also that of the physician. It may be remarked, therefore, that much unpleasantness on the day of departure could be avoided were the patient informed concerning the charges to be assessed against him. In this case forewarned is certainly financially forearmed.

Individualism in Room Rates Is Harmful

Hospital administrators for many years have been seeking some method by which room and specialty fees might be standardized. Nevertheless a confusing and harmful competition continues to exist. It seems, for example, that if in Hospital A a bed in a room of a comfortable size with two or more windows can be secured for a certain sum of money a day or a week, like accommodations for like charges might be expected in Hospital B. This is far from the truth. Those who determine room rates are inclined to display a vast degree of harmful individualism, the fee for each being set without any valid reason existing for relative difference in cost. To be sure, when competition is keen hospitals are forced to present rate cards which compare favorably with those of institutions near by. On the other hand, it does not seem reasonable to the patient to be charged a maximum fee for the

use of a room in one institution when but a few weeks previously his wife or his daughter occupied a similar or better room in another hospital at a lower rate. The patient is perfectly justified in believing that the hospital is not playing fair with him when such occurrences take place and he does not usually spare the administrator's feelings in giving his opinion on the subject. The hospital thus is in danger of losing the confidence of the patient, particularly if after a stormy protestation the room rate is rebated.

A Salesman Without a Price List

In some institutions the same deadly comparison may be made between the charge for rooms in various departments. It is ridiculous that an extra window or even an added chair should frequently be the reason for a material increase in the rate of a particular room. If, perchance, a diminutive corner washbasin has been supplied, it is not unusual for a dollar or more a day to be added to the room rate. The patient who is at all inclined towards statistics, while convalescence is progressing is prone to compute the usurious interest the hospital is thus securing as a result of the expenditure of so small a sum of money. The availability of a private bath usually is considered by the patient a satisfactory reason for an increase in the rate of a room. It appears that some attempt should be made to answer the patient's query as to the rationale of methods employed by institutions in fixing room rates, particularly in communities where a number of hospitals exist.

Reference has already been made to the manner in which the patient may more or less definitely estimate the expense of hospital treatment before he has actually incurred this obligation. Physicians are all too casual in informing the members of the family on this subject prior to the entrance of the patient into the hospital. This is often due to a lack of information on this subject on the part of the doctor himself. He thus becomes a salesman without a price list.

The careful physician, once hospitalization has been decided upon, calls into conference the responsible members of the patient's family if a serious illness exists, and informs them concerning the price of accommodations at the institution of his choice. This is only fair and reasonable. They should be told something concerning the nature

and location of private rooms. They should certainly be informed concerning the fact that the room rate includes housing, food and floor nursing. They should be instructed as to the fact that a semi-private bed is one to be found in a small ward. The approximate number of other patients in this ward should be stated. They should be told that occasionally other patients are delirious or noisy and that on visiting days there is likely to be much confusion created by the visitors to the several patients in this area. If laboratory, x-ray, electrocardiographic or other studies are likely to be necessary, they should be told that these charges will be in addition to that set for the room or ward bed. If these facts are made known, there can be no excuse for a later statement by the person financially responsible that he was not able to anticipate the expenditure of such a large sum of money as is represented by the final bill.

Hotel Rates Versus Hospital Rates

The public when considering hospital charges is prone to think in terms of hotel rooms. It is common knowledge that such accommodations can be secured at varying rates, from \$3.50 upward a day. The patient forgets that the hospital to a greater or lesser degree is conducted on the so-called American plan and that usually his rate for a hotel room does not include food. The patient who complains that \$6 a day is an exorbitant charge for a hospital room fails to consider that whereas comfortable accommodations might be secured for a like figure in a modern hotel, fewer persons are needed there to provide for his comfort.

While the organization necessary for the comfort of hotel guests is a complicated one, it does not approach either in scope or expense the personnel necessities of the hospital. To be sure, rooms vary in expense in the average hotel, ocean, river or park frontages commanding higher rates than rooms elsewhere. To some degree this is true in the hospital. It may be said, therefore, that the patient is often perfectly justified in complaining concerning room charges if he has not been shown a rate card prior to admission. When he has been informed of its cost, however, he has accepted an obligation to pay for hospital service, and hence he has no just cause for complaint.

But a question as to the fairness of room rates is not the commonest source of complaint on the part of the patient. He is surprised to learn for the first time that not only has he been charged a per diem rate for his room, but also that he must pay at least as much again for certain services of which he knew little or nothing upon admission. Usually this is the fault of the physician, although almost as often the admitting clerk is to blame.

Hospitals would do well more uniformly to present to the patient or his relatives on admission a detailed statement of all hospital charges. When the institution has a flat laboratory rate the patient is usually content to pay this amount. On the other hand, when this plan is not followed, he frequently desires to know why he is charged \$5 for a serologic test in Hospital A while in Hospital B for a like service he is assessed double that amount. If an electrocardiographic study can be skillfully performed in Hospital B for \$10 he has a right to know why a similar study requires the expenditure of \$15 in a second institution. If it has been necessary for the patient to undergo a surgical operation, why, he inquires, should the operating room fee be twice that which he paid to another hospital but a few months prior for an identical service to another member of his family. Likewise, it seems reasonable to inquire why hospital charges in the same city should vary from 50 to 100 per cent for the performance of such services as the removal of tonsils, the setting of a fracture, the administration of an anesthetic or the performance of a minor surgical operation.

If, after the service has been rendered, a bill is presented that to the patient appears exorbitant, it is too late to restore the patient's tranquillity of mind either by explaining the charge or by adjusting the patient's assignment in the hospital in order to lower his daily expense to an amount within his ability to pay. In some institutions, as has been already mentioned, laboratory fees have not been grouped and individual studies are charged for separately. If the patient has had other hospital experiences, he rightfully desires to know the reason for the great variation in cost.

Which Are "Ordinary" Medicines?

The difficulty seems to lie in the fact that hospitals persist in existing without any regard to the practices and policies of those round about them. The patient rightfully believes that there must exist some standards by which the adequacy of good medical service may be measured. He has a right to expect that in a group of modern and well administered institutions the performance of operations or study procedures should be equally effective. He cannot understand the justice of varying fees and immediately surmises that all is not well in one or all of the hospitals under comparison. The hospitals themselves have been responsible for this situation. The methods of correction are in the hands of those who are to blame for its existence.

There is another item on the patient's bill at which he looks askance. Hospitals usually supply ordinary medicine without extra charge. In the

definition of the term "ordinary" is found the fly in the economic ointment. Varying almost from day to day and dependent upon the current financial stress of the hospital will be the drugs deemed "ordinary." Indeed, the resplendency of the container or the amount of foreign print on the label often determines the question of the assessment of a charge. When the patient notes that thirteen cents has been charged on his bill for two cathartic pills or that ten cents is set down as the cost of a sleeping powder, he is inclined to look on this policy of the hospital as picayune. This is particularly so if he happens to be occupying one of the more expensive rooms in the hospital.

A Rate Card for Each Department

An overcharge he resents even more. If he is asked to pay thirty cents, for example, for a bottle of magnesium citrate when he can buy the same article at the corner drug store for less, he is likely to become disgruntled no matter how favorable the impression that had been hitherto made by skillful and humane treatment. It would be far better if a room rate could be set that would obviate the necessity of setting down to the patient's account such minor charges as those for cathartics, somnifacients, cardiac stimulants or intestinal antiseptics. It is a curious quirk of human psychology that the patient is satisfied to pay a not insignificant sum for a medicine or a service, the nature of which he understands not at all, when to be assessed a minimum figure for something concerning which he is well informed irritates him. Occasionally, however, the psychology of paying a small amount for a recognized drug or preparation in the hospital results in a logical query as to why he has been required to pay many times that amount for a similar preparation at the corner drug store.

Each specialty department, it seems, should have its rate card and certainly much unhappiness could be avoided were the patient always to be informed relative to the expense of the proposed treatment. For example, when a patient is sent from a private room to the department of physical therapy for massage or electrical treatment, he has no way of knowing that an extra fee is to be charged therefor. If, however, he has been informed by his physician or has had access to the rate card, he is prepared to receive a bill for this service. A flat rate for physiotherapeutic treatment seems wise. If, for example, the patient is told that when he is sent to this department he will receive all the treatment necessary to his welfare for a minimum fee, his mind will be set at ease and he will be inclined to be complimentary instead of faultfinding.

It has been suggested that the patient should reach some understanding with the physician as to

his fees for professional service during the patient's hospital stay. This, of course, is largely an individual matter with the doctor concerned, but it appears that the patient has a right to know what to expect. He has no ability to judge as to the money value of professional services, but he is justified in inquiring why conscientious and skillful care from one physician costs but a fraction of the amount charged by another for no greater service. While the hospital usually cannot interfere with the personal arrangements made between doctor and patient, yet when fees are exorbitant the hospital is affected immediately.

Too infrequently does the physician inform the patient's relatives concerning the expense necessary for private duty nursing. In some hospitals this matter is given no attention as is the case with the physician's fee, it being considered a personal matter affecting only the nurse and the patient. This plan, however, is thought by many to be unwise and a rate is set by many institutions to which special duty nurses must conform.

It would be a splendid thing for the patient if more institutions were able to estimate the total expense per day or per week of hospital care, if physicians' and nurses' fees were known in advance, if routine and specialty charges could be accurately estimated. Policies, however, vary the country over as to the adoption of flat fees covering hospital service. In many localities it is the belief of hospital boards that they should assume no responsibility for the collection of doctors' or nurses' fees. If this is not done, there can be no standardization of these charges.

Patient Resents Being Treated as a Child

In certain cities where a serious attempt has been made to offer hospital service at a minimum expense to those of moderate means, a maximum charge for various types of medical treatment has been set and the hospital has made itself responsible for the collection of physicians' fees as part of this flat charge. More often has it been found feasible for the patient to reimburse the hospital for special nursing charges, the latter in turn paying the nurse's salary. There is but little doubt that the physician more often would receive his fee if the amount he intended to charge were stated in advance.

It is questionable, however, whether hospitals routinely should assume any bill collecting duties insofar as the doctor and the nurse are concerned. The contact of the ambulatory patient with the hospital is not always satisfactory from his standpoint. When rushed into an accident ward because of an unfortunate trauma received on a city thoroughfare he frequently is not informed either con-

cerning the necessity or the expense of x-ray study or of surgical treatment. A sense of proprietorship is resented by the patient who is hurried from room to room like an automaton without his consent or even his knowledge as to his destination, or as to the seriousness or nature of his injury. Frequently he is told brusquely that he must pay for a service before it is rendered. Too often he finds himself occupying a hospital room without his family physician having been informed as to the occurrence of his accident or even in some cases without the members of his family having been summoned. He resents being treated as a child. He is offended at the apparent attitude of distrust as to his honesty.

All of these faults in the eyes of the patient appear grievous. He is inclined to characterize the hospital as mercenary, machinelike and cruel. In many hospitals the quality of efficiency has in a measure replaced old-fashioned courtesy and humanitarianism. This has not taken place intentionally nor is it the desire of many hospitals to neglect the individual rights and needs of the patient. The patient who goes to the hospital for a minor surgical procedure, such as the excision of a cyst or the incision of a furuncle, cannot understand a \$5 or \$10 charge for a few minutes' use of the operating room or for the administration of a local anesthetic. Such misunderstandings would not occur if he were courteously informed concerning the necessity for expenditures in his behalf which are not readily apparent to him. Hence, it appears, that most of the complaints against hospital charges could be obviated were the patient uniformly treated as an adult individual and less often as a mere inanimate unit in the day's work. Unfortunately much of the public's complaint

against the hospital has arisen because of the mistaken belief that such an institution must give unlimited free service or be unworthy of its name. A false sentimentality has arisen which demands immediate institutional response to every emergency but which is offended at any descent to such a gross plane as that of finances. The husband, elevated to a high degree of emotionalism at the thought of the birth of his first-born, resents the hospital's insisting that at least it be reimbursed for the expense entailed in his wife's care. Moreover, he sometimes denounces as venal the attitude of the hospital when he is charged \$1 a day for the maintenance of his child.

Certainly one of the by-products of the present depression lies in the education of the public as to the necessity and the fairness of the demand that the hospital be paid for its services. Institutions must be reimbursed for their services, else all must close their doors. Here and there will always be heard complaints against the hospital. If the institution seriously reviews every charge made for service, if it prepares rate cards covering each such charge, if it urges its physicians to inform their patients concerning hospital costs, if the admission office distributes this information on every occasion, fewer complaints will be received.

But this statement does not imply that present fees are always fair, or that any sane and just process has been employed in fixing these charges. If in sheer desperation the hospital yields to the temptation of profiteering in any of its departments, it will be doing itself a greater harm than any benefit that might accrue from an increase in revenue. Each newly admitted patient should find prominently displayed in his room a clear-cut businesslike statement of hospital financial policies.

United Hospital Fund Presents Its System of Accounting

"Accounting and Business Procedure for Hospitals" is the title of a volume that was prepared as the basis for the accounting classification and business procedures of the voluntary hospitals participating in the receipt of monies distributed by the United Hospital Fund, New York City. The author is Herbert R. Sands. The book is both a reference work on hospital administration and a handbook of accounting technique. In addition to a suggested uniform classification of accounts for hospitals, it includes many practical procedures for accumulating medical statistics.

The accounting procedures include certain original and commendable features, such as: (1) the emphasis on the balance sheet as necessary to adequate financial records; (2) the calculation of a "cost per in-patient day" which excludes the costs for "special services"; the accrual basis for income and expense, and the regular depreciation

allowances for hospital equipment and apparatus. Unfortunately the "interest expense" items are merged with the other accounts in such a way as to require special calculations when "fixed charges" are to be segregated from "operating costs."

The broad accounting categories for operating expenses are as follows: administrative and general; house and property; professional care of patients, general services; professional care of patients, special services; out-patient department; private ambulatory; education, and research. Under each of these categories there are subsidiary departmental accounts, many of them with subclassifications under such titles as salaries, supplies and services. It would have been useful if specific recommendations had been made for small hospitals that desire to organize a simple accounting system.

The book contains sound advice as to the calculation of patient days, the unit costs of special services, the comparison of income and expense for the various hospital activities and the segregation of education and research expenses.

Proper Selection of Students Means Better Trained Nurses

By CHARLOTTE F. LANDT, R.N.

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NO SINGLE profession or member thereof is completely separated from the rest of the world. There is an interrelationship and an interdependence from which no person or thing is entirely free. Similarly, new ideas have an interrelationship with what has been done in the past. Previous accomplishments act as an assurance of what can be done and will be done in the future. The day of the pioneer is not over. We are all pioneers and each generation builds upon the accomplishments of those that have gone before. The nursing profession is in a continuous state of evolution and it behooves nurses to pause and take an inventory of the past as they judge the present and make an effort to meet the demands of the future. Past accomplishments are as one continuous experiment which may act as a guide, as an inspiration or as a warning. They serve as guideposts for future planning.

Unemployment in nursing has become a distressing problem. Records clearly show that unemployment in nursing has been going on for years and has been steadily increasing. Although it is now widespread it is not entirely caused by the prevailing depression.

Quantity Versus Quality

With approximately 25,000 nursing students graduating each year, this problem has become truly formidable. There are various causes for this growing lack of employment and one cause lies in the fact that schools of nursing have for years allowed the need for nurses in the community to be governed by the need for students in the hospital. It involves also the educational system (handed down to us from the far distant past) which requires that the number of students shall not be reduced to such a degree that it interferes with the efficient care of the patient, a responsibility which, after all, is the hospital's chief concern. Here, it seems, the present depression has a direct bearing upon the difficulty since many hospitals are financially unable to reduce the number of students and to employ in their stead an equivalent number of graduate nurses and ward maids.

When student admissions are governed by the numbers needed in the hospital, quality cannot be maintained, and the Committee on the Grading of Nursing Schools has shown that many nurses who today are seeking relief are unqualified for any of the positions that are available.

No Place for Misfits

From the standpoint of overproduction we must select fewer students and from the standpoint of native and professional qualifications a more careful selection must be made. If we are to choose fewer and better candidates for our schools we must pay more attention to the social, economic and intellectual background of the young women whom we wish to admit. We cannot develop highly qualified nurses or provide quality nursing if we continue to accept the failures from high schools and colleges or the applicant whose I. Q. fails to reach 100 or over. We shall not get far in the solution of our problem if we continue to accept and to graduate from our schools misfits who are either turned away from or dropped by another school. These unemployable individuals are more sinned against than sinning and a sense of deep responsibility should be ours because of their presence in our profession.

Improvement of nursing procedures, better prepared faculties, a more carefully planned educational program, improvement in teaching facilities—all of these reforms are of little value if we continue to admit applicants who have failed in other lines of endeavor, or if we continue to ignore the content of their high school course and also the quality of the work they have done there. We owe it to these young women as well as to our profession to avail ourselves of every means for determining their aptitude for nursing before they are taken into the school. It is not fair to them to lead them to believe that they may become successful nurses unless the results of various tests indicate that this is possible.

Furthermore, it is expensive both to the school and to the candidate, in terms of time, energy and money, to permit her to enter and later on to re-

quest her to withdraw. Statistics show that approximately 50 per cent of all nursing students who enter schools of nursing either withdraw or are dropped before they graduate, but statistics do not show how many failures there are among those who do graduate. Under the failures let us include nurses who are unable to earn their living by doing a type of nursing that is needed in their community in such manner that it is satisfactory to the persons whom they serve.

The nursing profession is not the only one that is seeking better methods of selecting students. Medical schools are experimenting with aptitude tests and so are teachers colleges. Teachers College, Columbia University, is opening a new department which is to be devoted to a new type of teacher training system. One of its chief features will be its exacting method of selection of students. This college holds that the best training in the world cannot make a superior teacher out of inferior human material. It also holds that mediocrity is today the curse of the teaching profession. May we not apply these statements to the nursing profession? If qualities such as high mental ability, worth while achievement, good character, abundant physical and mental health, sufficient energy, a pleasing personality, cultural interests, good habits, high ideals and sincerity of purpose are so essential in the teaching profession, are they not to be considered equally valuable in the nursing profession?

In accepting applicants for admission to schools of nursing, it is essential that we turn to all sources available in studies already made, to previous school records and to the opinions of persons who are well acquainted with the candidate and who also are conversant with the qualifications essential to good nursing, if we are going to graduate nurses who are well prepared to meet all the nursing needs of the community.

Are Two Types of Schools Feasible?

High schools, through their vocational guidance departments, must be informed as to our needs in order that they may intelligently advise young women who are planning to enter a school of nursing upon graduation. Courses must be made available in high schools which will offer a better background for the nursing course. Educational prerequisites to the course of study in a school of nursing should not be so much in terms of years as in content of work accomplished and how well it has been mastered. We wish to know not only whether the applicant has ranked in the upper third of her class, but also what her scholastic achievement has been in comparison to the other members of her class. Is it not wise also to ascer-

tain the standing of the school from which she graduated?

For many types of nursing a high level of intelligence is essential, but are we going to bar the otherwise desirable young woman whose I. Q. is only slightly above 100? In other professions are found, it is said, highly successful individuals whose intelligence is only slightly above average, but their character and personality, their degree of application, their sincerity and their seriousness of purpose promise success. Undoubtedly there are many successful members of the nursing profession who could be included in this group. Would it be possible to classify our schools into those preparing students for executive and teaching positions and those preparing students for only bedside nursing? By means of committees or boards could we select, evaluate and direct applicants into the appropriate schools? There remains much to be said both for and against the plan which these questions suggest.

Can Schools Become Financially Independent?

Nationwide state legislation should be enacted which would make graduation from a four-year high school course compulsory for admission to schools of nursing, and the proper steps then should be taken to see that the law is enforced.

There is also much to be done in the way of educating the public as to whose responsibility it is to bear the financial burden of educating the nurse. If the public has accepted the responsibility, at least in part, for educating the doctor, the dentist, the lawyer and the engineer, why should not the public be made to understand that the nurse also should be included. And again: the young man or woman who decides to study medicine, dentistry, law or engineering fully expects to bear at least a part of the cost for his or her education. Why then should the nursing student be excluded from this prevailing system of financing education? It is true, likewise, that endowments, too, are more common in other professions than in the nursing profession. May we not in great measure consider ourselves to blame for these conditions?

You may ask what bearing this has upon the topic of this paper, but should we not investigate the candidate's economic background to learn in what manner she expects to finance her education? Is it possible for schools of nursing to become financially independent? Does this not open a vista of possibilities? We also should inform the applicant of her status if and when she graduates, especially insofar as her economic independence is concerned. She should be informed of the oversupply of nurses.

Mental tests alone will not enable us to retain

in the school all the students admitted even when the testing is done before admission. We must institute a series of achievement and adaptability tests. There are standardized tests available in silent reading; speed and legibility in handwriting; spelling ability and ability in elementary arithmetic, especially in fractions and in the decimal system. Speed and comprehension in reading will forewarn us of unprepared assignments and of the student's degree of alacrity in comprehending orders. Speed and legibility in handwriting, together with her ability to spell, will tell us how much time and energy will need to be spent in teaching her accuracy in charting and in the writing of reports.

Since the course in arithmetic upon which the problems in drugs and solutions are based usually is included in elementary education, the greater number of our nursing students are completely at a loss when asked to solve the problems presented in elementary materia medica. Would it not be reasonable and permissible to inform these applicants of the achievement tests that are to be given before admission and thus give them an opportunity to review at least their elementary arithmetic? It surely would save much of the instructor's valuable time now being spent in reviewing these simple arithmetical problems.

Character and personality tests also are invaluable in that they reveal introvert and extravert tendencies and thus give us a clue to the applicant's inherent qualities of leadership. We should desire to have in our schools students who have

ideas and theories of their own and enough self-confidence to wish to express them, rather than those who willingly submit to stern discipline and yield to everybody's whims and commands. We should want them to question and challenge. That desirable submissiveness of the past is not conducive to the development of initiative and the ability to think things through; hence, it becomes a serious handicap to nurses when as graduates they are thrown upon their own resources to become either successes or failures in their professional careers.

Nor should a complete physical examination be overlooked. It is advisable to request a report from the candidate's family physician as to her physical condition and also a statement from her dentist, with the understanding, however, that a complete physical examination is to be made by the school physician before the candidate is admitted to her classes. It is desirable to have an x-ray picture of her chest prior to admission into the school and also at the time of graduation. Since the actual cost to the hospital is not excessive, it is recommended that a chest x-ray be taken once a year at the time of the annual physical examination.

As a comparatively small sum is needed to institute a complete testing program even before young women are admitted to schools of nursing, would it not save the hospitals considerable expense were they to take advantage of these opportunities when selecting their students?¹

¹Read at a meeting of the second district of the Association of Graduate Nurses of Colorado, Denver.

Liability of a Charitable Hospital for Injury to Visitor

Is a charitable hospital liable for injuries sustained by visitors? "No," said the supreme court of New Jersey in reversing the decision of the trial court in a damage suit filed by a visitor who was injured on the premises of the Orange Memorial Hospital, Orange, N. J.

The supreme court's decision follows:

The plaintiff's daughter was a patient in the defendant charitable hospital. While leaving the hospital after visiting her daughter, the plaintiff slipped and fell on the stairs and was injured. To recover damages for her injuries, she and her husband sued the hospital. It was alleged that the stairs were covered with some slippery substance; that the supervising nurse in charge of the hospital premises was negligent in not discovering the slippery substance and having it removed, and that the nurse's neglect was imputable to the hospital. The trial court refused to direct a verdict in favor of the defendant hospital, and the hospital appealed to the supreme court of New Jersey.

The New Jersey Court of Errors and Appeal, said the supreme court, held in *D'Amato vs. Orange Memorial Hos-*

pital, 101 N. J. Law 61, 127 A. 340, that such a charitable institution is by public policy not liable for injuries to patients, even pay patients, resulting from the negligence or carelessness of its physicians or nurses. Applying that principle, the patient herself in this case, even though a pay patient, could not have recovered damages if she had been injured by falling on the slippery stairs of the hospital.

But the plaintiff, it was argued, might recover damages, because she was not a patient, but only a visitor. The plaintiff, said the supreme court, entered the hospital voluntarily and for her own purpose. She had no invitation from the defendant hospital, other than such as was implied by the privilege of visiting the sick, given by the rules of the institution. The opportunity thus afforded was part of the charitable service which the defendant was rendering to suffering humanity. Accepting the principle, as applied to a charitable hospital, that public policy denies to a patient injured through the negligence of a nurse the right to recover damages for her injury, the logic of the rule denies that same right to those who in visiting patients are injured from a like cause. The liability of the defendant hospital was not shown as a matter of law, and the trial court should have directed a verdict in favor of the hospital.—*Boeckel vs. Orange Memorial Hospital (N. J.), 158 A. 832.*

Editorials

The Hospital as a Competitor of the Family Physician

DISPENSARY abuse has been the shibboleth of doctors and laymen alike for almost as long as out-patient departments have been in existence. Moreover, the reputed dimensions of the problem have consistently been in direct ratio to the vividness of the imagination of the narrator. To some, every patient who is able to pay a fee of any size should be referred to a local practicing physician. It is believed by others that only those able to pay the customary office fee of near-by doctors should be refused by the hospital clinic.

There are those who without question will and do abuse any gratuitous service. Many no doubt secure treatment from the institutional out-patient department who could and should afford private care. But the technique for routinely ferreting out the impostor, for separating the undeserving from the worthy, has not as yet been developed. Moreover, the hospital during the past few months has often permitted an abuse to develop which places it in direct competition with the family doctor. Not only in the dispensary but in the accident ward as well are patients treated for all types of both trivial and potentially serious ailments when the only explanation of the presence of such persons there is an effort on their part to secure gratis a service for which they should pay. No institution can expect the full cooperation of its local physicians which thus unfairly competes with them. To refer such patients promptly to their family doctor is not only an act of justice to the physician, but also one fraught with sound business sense.

A School for Courtesy

COURTESY is the keystone of good service. When practiced, it is often so spontaneous and natural that its presence is scarcely noticed, but when discourtesy replaces it all realize its absence.

The hospital should be the natural habitat of this splendid virtue and yet if bad manners were as frequently displayed in the business world as in the hospital, creditors would oftener have cause to complain. While there are outstanding exceptions to this statement, its truth is too often manifested.

Why should this be? Hospital employees are

often underpaid, their ability to perform their duties satisfactorily is too frequently taken for granted, the income producing possibilities of politeness are overlooked, skill is not developed in understanding and meeting members of the public who are difficult to deal with because of their anxiety or grief—all these are comprehensible explanations of the offensive tactics adopted by some hospital employees in their dealings with the public. There is no valid reason, however, why these faults should continue to exist.

Information clerks should be carefully selected and schooled in meeting visitors with understanding courtesy. Accident ward attendants should be instructed so that they will differentiate between the methods necessary in dealing with a malingerer and those that should be adopted in dealing with a cultured stranger who has met with an unfortunate accident. The hospital officer who becomes brusque, callous, blasé, be he superintendent or private floor orderly, should be reformed or replaced. A school for courtesy would be an admirable activity for any administrator to conduct.

The Hospital Orderly Again

"Albany, N. Y., February 13. Among 1,534 admissions to Sing Sing Prison during 1932 the State Department of Correction said today that there were no . . . physicians, editors or ministers. . . . Among the low ranking occupations there were forty-one hospital orderlies. . . ."

OPINION will be divided as to the justice of such an arbitrary classification as appears in the news item quoted in the preceding paragraph. Many will hold that the editors should have some representation; others may bear some doctor a grudge for which they think he should have been incarcerated; but most of us will wonder why they pick on the hospital orderly. He has opportunities for humane service to the sick poor that no other worker, with the possible exception of the nurse, possesses. Indeed, if he is unmarried he is provided with full maintenance and a wage that most hospital administrators think should keep him out of mischief.

There are several reasons for such disproportionate representation of hospital orderlies in jail. First of all, little interest is shown by the personnel office of the hospital in the proper selection of qualified applicants for the work of the orderly. In most instances the situation is considered hopeless. Many administrators feel that the orderly has not yet been born who is not by nature perverted, or addicted to alcohol, or dishonest in various grand and petty ways. Why should any able-bodied man with average intelligence, they argue subconsciously, stoop to the kind of work that an

orderly must perform on the wards. Hospitals do not give and check references carefully and the result is that you can count the good orderlies who stay put for long periods of time in any hospital on the fingers of one hand.

When the orderly is employed his salary, with the maintenance factor taken into account, seems adequate. Perhaps it is too much, considering the type of man that is acceptable to many, and every administrator knows that the orderly expects to double his salary by accepting bribes on the wards. Favoritism thus raises its ugly head in an institution that is, or should be, built on a foundation of fairness to all, particularly when they are poor and cannot afford to buy immunity from neglect. Under these demoralizing circumstances, bribes can be given and accepted only with the connivance of the administration.

The hospital that will lead the way in a study of labor turnover among orderlies in all its phases will deserve the everlasting gratitude of the sick and will moreover purge a group of workers from a taint that is not altogether of their own creation. It is no fault of the good orderly that the hospital is careless in its selection and treatment of his colleagues at the outset, or in its interest in them later. As an example of what may be done with one phase of the problem one large hospital in the East has expressed its willingness to be patient with the orderly whose only fault is his addiction to strong liquor, and try to rehabilitate him through the efforts of the medical staff.

A somewhat advanced theory is generally accepted nowadays, that society must share in the responsibility for the criminal acts of its constituent members, and this is no less true of the responsibility of the hospital administrator for the orderly whom he employs.

Cause of Death: Peritonitis

IF YOU would learn the degree of skill possessed by the surgeons on the staff of any hospital, interview not entirely the happy homeward bound patient in the surgical ward—see the pathologist. For 'tis no other than this physician who has the opportunity of observing first-hand many of the surgical tragedies that transpire in the hospital. It is at the postmortem table that the death dealing effects of haste and of careless diagnostic effort are seen. The slipping of a ligature; the early digestion of a buried catgut suture; the missing of hidden pus beneath the diaphragm; the occurrence of a fatal infection of the peritoneum, all are accidents from the discovery of which the false scientist recoils.

Every such occurrence should be given full and pitiless publicity in staff meetings. What does the dignity of the surgeon matter when human life is at stake? If the excision of gastric ulcers has been found dangerous in the hands of the staff of any hospital, let some other procedure be substituted by staff enactment. If the postpartum use of any drug in the maternity department has proved dangerous, its administration should be forbidden. Fear of interfering with the professional prerogatives of the individual physician should not exist when the welfare of the patient is at stake.

The physician who is sure he is always right is a danger to the community and to the reputation of the hospital. He who is inclined to humility in the presence of the manifold unknowns in medicine is a safer prophet to follow.

New Incomes for Old

IF ANY one lesson has been learned as a result of the present day necessity for new economic alignments, it is that of the value of the quality of personal flexibility. Woe betide him who has become so grooved in matters of personal routine or of business that a new day finds him unable to adjust himself to its requirements. Nations, as well as individuals, have been moved by urgent necessity to readjust their business lives so as to carry on with any degree of efficiency.

The hospital, perhaps to a greater degree than in any other type of activity, is likely to routinize unduly its daily work. Bound by traditions, some of which, although irrational and unbusinesslike, have been followed as a matter of course, the hospital in the belief of many has been actually hindered in its progress. There are those who conclude that to derive any income from the sale of a service or a commodity already retailed by neighborhood tradesmen is an unwise, if not an unfair, practice on the part of the hospital. To sell drugs, flowers or confectionery to the public or to provide laundry, beauty culture or tailor service to guests and their friends and relatives is believed by many to represent activities not rightly associated with the conduct of the hospital. There is, however, a growing belief that in many instances it is not only a right but sometimes an obligation of the hospital to accommodate its patrons by providing facilities such as these.

Whatever the local belief and practice, the changing attitude of trustees and executives in regard to the ethics and the business wisdom of offering for sale within the hospital those articles for which there is a real demand is noticeable. Perhaps hospitals have been too tardy in noting

and practically applying the trends of present day business practices. Perhaps the fear of offending local dealers has been ill-founded because such business obtained by the hospital would not lessen the patronage of community retailers. In any event, the hospital while seeking for new incomes to replace lost old ones should not sacrifice the moral and financial support of any class of the members of its clientele. It is wholly possible that there is less danger for such a misunderstanding on the part of local merchants to occur now than there was a decade ago.

Tonsils and Adenoids

IT WOULD be instructive for the profession of administrative medicine to institute a tactful inquiry now and then as to the value of certain operative procedures done by wholesale nowadays in the best hospitals of our country.

Methods of clinical auditing have never been developed to the entire satisfaction of the governing authorities of hospitals and the scientific staffs appointed by them, and the contrast between the universal lack of a clinical audit and the uniform insistence upon the periodic financial audit is indeed striking. This is doubtless due to the desire of the administrator and his superiors not to trespass on the territory of the men of science who compose the visiting staff and not to pry too closely into their medical practices, on the assumption that they are able and willing to comply conscientiously with the minimum requirements of the American College of Surgeons on this point. The visiting staff serves, in the greatest part, without financial return, taking its reward in prestige and in medical practice, and it is generally felt, though somewhat erroneously, that the old axiom about looking a gift horse in the mouth must be borne in mind.

If, however, a method could be found for harmonizing the viewpoint of the governing authorities, who provide the best available facilities for the practice of medicine to qualified men, and the viewpoint of the visiting staff, who have so much confidence in their own skill, a great many facts would come to light which might be useful to all.

We are prompted to comment thus by an illuminating article in the *British Medical Journal* for Sept. 10, 1932, entitled "The End Results of the Tonsil and Adenoid Operation in Childhood and Adolescence," by J. Alison Glover and Joyce Wilson. The authors point out, in one of those exceptionally painstaking statistical analyses, that the rising flood of tonsillectomies is proved by the rapid increase in the number of these operations annually performed and by the astonishing fact

that more than half of the most carefully nurtured children in England are now subjected to it, whereas forty years ago none of their parents underwent the operation. They prove, for example, that while the incidence of tonsillitis is at least as high among the poor as among the well-to-do, the children of the latter have an incidence of tonsillectomy at least four times as high.

On the basis of a review of the literature, the authors state that with the single exception of diphtheria the incidence of the ordinary infectious diseases is unaffected by tonsillectomy. This includes the common cold. There is more than a hint in what they say that ear and mastoid disease, as well as bronchitis and pneumonia, show a slight increase among those who have undergone the operation. The evidence with regard to the prophylactic and therapeutic end results of tonsillectomy on acute rheumatism, chorea and heart disease is distressingly confusing. Basing their inference on a study of 14,000 children, among a given school population, in which 50 per cent were tonsillectomized, they find no statistical support for the theory that the removal of tonsils closes an entrance for infectious or respiratory diseases. They quote Cunningham who found in an older group of children that tonsillectomized pupils gave a history of higher incidence of all illnesses.

The authors of this thoughtful study are apparently not interested in making sweeping statements which might be used as a basis for too much criticism of their colleagues. The literary tone is indeed restrained, as the following eloquent paragraph which closes their article will prove:

"We hold no brief for the retention of diseased or really obstructive tonsils or adenoids, nor do we wish to cast doubt upon the high value of the operation in cases in which there is sure evidence of toxic or obstructive damage. A review of the literature and the epidemiological observations made on a highly tonsillectomized child population suggests, however, that the excellent end results of tonsillectomy in selected cases have been statistically overweighted by indifferent end results in cases in which the operation has been performed without sufficient indications as a more or less routine prophylactic ritual. In our opinion, a large proportion of the tonsillectomies now done in children are unnecessary, entail some risk and give little or no return."

The hospital administrator who reads articles like these by scientific men in reputable medical journals has the right to ask his visiting staff for an explanation and, if this is done with all the precautions dictated by good statesmanship and diplomacy, the results should be far-reaching in their influence on hospital service.

The Problem of the Month:

How Can Noise Be Controlled in the Hospital?

COMPLAINTS have been numerous in one hospital that maids and student nurses are excessively noisy in the utility rooms and floor kitchens. Instructions for quieter working methods and even threats of dismissal have been of little or no avail.

Is it a construction problem, a disciplinary one or an unavoidable situation?

How would you attend to the matter? What have you done to decrease noise within the hospital?

*John M. Smith, Director,
Hahnemann Hospital, Philadelphia:*

"Complaints regarding noise made by nurses and other personnel in utility rooms and floor kitchens are not uncommon in hospitals.

"Some of this noise is unpreventable under ordinary working conditions but a great deal of it is entirely unnecessary and is due to carelessness and a lack of interest in the patient. Some of it can be kept from the patients if the service rooms are properly located, and if they are provided with soundproofed walls and suitable doors. Acoustical treatment on the ceilings and walls of these rooms is a great advantage.

"In planning our hospital we placed these rooms as far away from the patients as possible and made them in reality part of the service elevator lobbies, there being a three-quarter-height partition between them. There is acoustical material on the ceilings of the bathrooms and there is a double hung door leading into the main corridor. The private room floors are so designed that each one is a complete nursing unit. The bedpans for instance, are emptied in the toilet room adjoining each room. Each one of these individual private toilets is provided with its own bedpan, irrigator, male urinal, dressing basin and washbasin. As a result, the noisy work which a nurse must do for a private patient is kept within that particular unit.

"The importance of preventing noise is explained to the maids and other members of the housekeeper's staff. If they are the cause of noise and the housekeeper hears of it they are talked to plainly. If, as occasionally happens, such an em-

ployee persists in being noisy she is either transferred to some other part of the house where the absence of noise is not essential, or she is dismissed.

"How to handle nurses, particularly those doing private duty work who are not our employees, and student nurses, is a difficult problem. We sometimes warn special nurses that we expect a higher grade of service from them and that if we do not get it the nurse is not welcome. It is becoming increasingly difficult to discipline student nurses because state boards are showing a strong tendency to demand more lenient handling of them. We understand that recently state boards have written heads of schools of nursing that the punishing of nurses by taking away their hours off and denying them late passes, or adding to the time necessary to serve before graduation, are not regarded as proper and yet all of us probably realize that there is no punishment unless a person is inconvenienced, humiliated or denied a privilege of some kind. Unfortunately it is sometimes necessary to punish nurses in order to impress upon them the need for proper performance of their duties."

*A. E. Hardgrove, General Superintendent,
City Hospital, Akron, Ohio:*

"Three different types of construction in our hospital group prove that elimination of noise is almost entirely a construction problem. Every effort to reduce noise in two older buildings has failed to produce the pleasing results that were easily obtained in the newest building designed with this purpose in view.

"Among the measures taken in construction of the newest building were: placing the elevators on the side corridor; placing the nurses' desks in a side room opposite the elevators; placing the waiting and convalescent room in the center of the building opposite the side corridor, thus leaving the ends of the building entirely for patients; covering the ceilings of all the service rooms and corridors with acoustical material; the use of rubber flooring in the corridors; the provision of sufficient storage space and utility rooms; the provision for as much individual service at the bedside as possible in order to reduce traffic and decentralize

noise; the universal use of door closers and checks, and providing a central dishwashing room for the entire building on the service floor.

"Efforts that have been helpful in old buildings are: the complete use of rubber tired casters or silencers on all furniture; the insulation of the utensil racks and utensils, where possible, with rubber silencers; covering the radiator type bedpan warmer with asbestos; the use of acoustical material as above, and the use of proper floor material.

"Much more can be done by this type of program than can be accomplished through disciplinary measures."

*E. L. Slack, Superintendent,
Samuel Merritt Hospital, Oakland, Calif.:*

"There are two factors to consider, as I see it, relative to sound control in any institution. First, hospital workers must be 'noise minded,' as it were, and by that I mean they must be conscious of the fact that they are employed in an institution whose sole existence is for the care of the sick.

"Supervision should not be relaxed for one moment. The employees should work as quietly as possible and the equipment should be in good condition. The cooperation of the professional staff of the hospital must also be enlisted to decrease this nuisance.

"The other factor, which is of equal importance, is the type of building, the type of hallways and whether or not modern sound absorbent material has been installed."

*Dr. Herman Smith, Superintendent,
Michael Reese Hospital, Chicago:*

"The noise incident to the ordinary work in utility rooms and floor kitchens does not have to be excessive to cause complaints. It is obvious that all precautions should be taken to make equipment as quiet as possible. Constant admonition has to be given to nurses and other personnel regarding the banging of utensils and the necessity of keeping doors closed.

"Even with these precautions I do not believe that noise in these two places can be eliminated without sound absorbent treatment of the ceilings or walls, or both. To my mind, it is quite obvious that this is the only method of solving the problem because we are insisting and correctly so, that the walls and floors of these rooms should be of hard materials which can be washed easily, such as tile and terrazzo, and with this type of sound reflecting surface no correction is possible other than sound absorbent treatment.

"By attention to details and by admonishing the

personnel to be quiet, we have made some progress in decreasing noise in utility rooms, but the only real progress we have made in quieting these places has been in the rooms in which we have placed sound absorbent material on the ceilings."

*Ada Belle McCleery, Superintendent,
Evanston Hospital, Evanston, Ill.:*

"In order to reduce noise three factors that play a part in the making of noise should be studied: personnel, articles handled and construction of the building.

"Often the employees are not sensitive to noise. This is more noticeable if the worker is young and healthy. The first step, therefore, is to make the worker noise conscious. This is, I admit, a discouraging task and especially so if admonition alone is relied upon. Better results may be attained by taking the necessary time to secure the interest of the workers in the problem and to give them an understanding of its relation to the comfort of the patient.

"Quieter working methods are important if the handling of articles is to assist in noise reduction. Metal striking metal, and china striking china are nerve racking because of their monotony and persistency. The use of cloth or rubber as a pad, handling dishes one at a time, thereby reducing such contacts to the minimum, the more careful placing of utensils on rack or in sterilizer, will help deaden this type of noise.

"The third factor is the one of construction. A separate service corridor is ideal but expensive. Double doors help if they can be kept closed. Since we must continue to use the buildings at hand and postpone the carrying out of our theories until more prosperous days, the most practical suggestion, as far as construction bears on the problem, is to apply acoustical treatment to the ceilings."

*Dr. Joseph B. Howland, Superintendent,
Peter Bent Brigham Hospital, Boston:*

"Complaints that maids and student nurses are excessively noisy in utility rooms and floor kitchens are to be expected unless these departments, which are naturally noisy, are either sufficiently far from patients or are protected by mechanical means. Student nurses and ward maids are not the only hospital employees who are apt to be careless in this respect. Doctors forget and visitors to patients also are responsible for noises.

"First, an attempt should be made to see what can be done mechanically to overcome noises from utility rooms and diet kitchens. Usually, the better the building and the more expensive the fixtures,

the greater the noise. It might be possible, in some places, to make a vestibule inside of the kitchen or utility room so that there would be two doors.

"Many efficient sound absorbent materials are on the market and can be applied to ceilings and side walls. Soapstone sinks and wooden counters are inexpensive and comparatively quiet.

"Refusal to cooperate in cutting down noise should be cause for discharge of either a nurse or a ward maid, but others will be equally careless and it means constant policing.

"I recommend that the problem be approached first of all from the standpoint of altering construction and equipment so that even the most careless could make little noise. Possibly with the vestibule type of doors little noise would reach the corridor and thence the patient. The difficulty then is primarily one of construction and equipment, and secondarily, possibly a disciplinary one, but it should not be considered as one that cannot be remedied."

*Dr. Lucius R. Wilson, Superintendent,
John Sealy Hospital, Galveston, Tex.:*

"In order to eliminate noise in the floor kitchens and utility rooms careful thought should be given to this problem at the time of planning the hospital. The location of these rooms, while convenient,

should not be such that sounds arising there will be transmitted over the entire division. The walls should be constructed so that sound will not pass through them. Sound absorbent materials should be used wherever possible. All doors should have effective door closers and should fit tightly. After all possible precautions have been taken in construction, there will still be a certain amount of noise from this source that must be controlled.

"The human element is the largest factor in noise production; therefore, the personnel must not only be thoroughly trained to work quietly, but constant supervision must be employed to maintain that standard. Student nurses are taught from their preliminary period to their senior year to work quietly, to speak in a well modulated tone, and to walk without creating any disturbing noises. The dietitian and the housekeeper should require their employees to work with a minimum of noise.

"All equipment should be kept in good operating condition. Carts should have rubber bumpers and well lubricated rubber tired casters. Rubber mats on drain boards and tables are effective when dishes are being washed. Rubber padding on enamelware racks and shelves contribute to quietness in the utility rooms.

"After all these precautions have been taken, a perpetual warfare against noise must be waged."

Is a Positive Wassermann Reason for Discharging an Employee?

There is considerable hysteria nowadays as to the actual menace to society of a patient whose serology shows the presence of a former luetic infection. Concerning the significance of such a laboratory finding, "A little learning is a dangerous thing." Examinations of hospital employees, however, cannot be too thorough. In the course of such studies frequently a blood serologic reaction is found to be positive, and the administrator of the institution is sometimes confused as to what should be done. Most physicians believe that a thorough physical examination will disclose satisfactorily the infectiousness or noninfectiousness of the condition of a hospital worker. If a Wassermann test has been made and found positive, a thorough physical examination will often reveal that the condition of the employee is no more infectious than if the reaction were found negative.

Three Grounds for Immediate Discharge

As a matter of fact, Neisserian, luetic and tuberculous infections are the three conditions for which the hospital should most earnestly seek, particularly in selecting its food handlers. The presence of an active Neisserian infection should of course prove grounds for the immediate removal of a worker, until the infection has been properly treated. An active tuberculous lesion presents the same

indication. A four plus Wassermann reaction, however, may be interpreted as representing an infection of a decade or more in duration and often does not indicate in any way that there is a possibility of the transmission of the disease from one patient to another. A physical examination that does not disclose the presence of an initial mucous membrane lesion, a rash or any of the tertiary manifestations serves only to confirm this statement. Such a patient, however, should for his own protection be given active specific treatment, and even though his reactions prove to be Wassermann-fast, he still, all things else being equal, may be continued on the hospital pay roll without danger to the other employees or the patients.

Periodic Examinations Should Be Made

When we consider that a test of the blood of a large number of the members of any community will disclose positive Wassermann reactions in many instances, and when it is remembered that the examination of food handlers in hotels, restaurants and other public eating places is often carelessly done, if at all, it is safe to conclude that the hospital usually is more careful about this matter than the average public establishment. Nor is it the intention here to signify that the examination of hospital employees generally, and of food handlers particularly, should not be made a periodic and efficient routine. A positive Wassermann reaction without physical evidence of tissue infection should not disqualify a hospital worker from continuing in his occupation.

Maintenance, Operation and Equipment:

Ten Years' Use Has Proved the Value of This Key Filing System

By F. STANLEY HOWE

Director, Orange Memorial Hospital, Orange, N. J.

THE system of key control is important in a large institution that requires thousands of keys for rooms, cabinets, lockers and other fixed or movable equipment, and every precaution should be taken to ensure the economical and properly safeguarded use of keys.

In my early experience with a system wherein the keys and the records were kept separately, there was always the difficulty of the individual in charge failing to make notes on the record cards when keys were issued. Furthermore, the special nature of the cabinet or other container for holding the keys made it necessary to anticipate future growth on a large scale, or to duplicate special units from time to time. The system I finally adopted, and which I have used for ten years, seems to meet every requirement, both for completeness of record and for simplicity and economy in expansion.

A Simple and Positive System

The container is a strong manila envelope of a size to fit a 3 by 5-card file. There are blank spaces on the face of the envelope for recording the building, the number of the room or the number of each piece of furniture having a separate lock. Owing to the frequency with which desks and other pieces are likely to be moved from room to room with resultant changes in departmental organization, it is not sufficient to indicate a given movable piece by the number of the room in which it is first installed. Each piece should have a serial number stamped above the lock with steel dies so that it can be identified wherever it may be placed. This method is simple and positive in its operation. The name of the maker of the lock, the cylinder number, the date on which the keys are issued, the names of the persons receiving the keys and the dates when the keys are returned, or duplicates issued, are other data recorded on the container envelope. It is my experience that this constitutes all the information necessary for efficient operation.

All duplicate keys are placed inside the envelope,

which is sufficiently large and strong to hold four large bit lock keys and a larger number of the six-tumbler cylinder lock keys. The envelopes are filed in standard 3 by 5-inch card drawers, which may be obtained in any quantity necessary to meet the requirements of a given institution.

It is, of course, important that a key file be carefully safeguarded. This can be accomplished by placing an adequate lock on the filing drawer units, or, if standard storage cabinets are available, card file units made to fit inside of them can be procured. Each drawer front is plainly marked to indicate the keys it contains, and the system

KEY RECORD ORANGE MEMORIAL HOSPITAL		KEY NUMBER:	
BLDG. MAT.	ROOM: 315	FURN. NO. —	Yale 077354
DATE	RECEIVED BY:	RETURNED	REPLACED
Jan. 5, 1930	J. C. Smith	4/7/31	
Apr. 8, 1931	Robt. Brown	9/18/32	
Sept. 7, 1932	Frank Jones		

This shows how the data are recorded on the face of the key filing envelope used at the Orange Memorial Hospital.

can be expanded gradually simply by adding more filing drawers.

This system has been found to have the following merits:

1. When a key is issued, the envelope is in hand as a reminder to record the fact, without reference to a separate file.
2. Keys contained in envelopes do not rattle, cannot shake off of pins, and are unlikely to become mixed.
3. All information in regard to a certain key is available, obviating the difficulty of matching a key when the original blank bearing the cylinder number is lost.
4. There is a permanent record of all persons to whom a certain key has been issued.

5. The envelope system is adaptable to all sizes and types of keys, from the small padlock to the heavy bit lock key, whereas in other methods considerable space is wasted, as the equipment has to be made to accommodate the largest keys through-out.

6. The system expands or contracts readily and is compact and convenient.

Some institutions are equipped with key cutting machines, in the belief that it is an economy for a hospital to make its own keys rather than patronize a local locksmith. Unless the superintendent operates the machine himself there is always the possibility that other persons in the institution may take advantage of the machine to make duplicate keys. The great variety of locks that find their way into use in an institution call for a wide variety of blanks, and I doubt if many institutions can save money by keeping a stock of these blanks, as against letting the locksmith assume this responsibility. In our hospital keys are sent to the locksmith without any means of identification except as to the institution from which they come. An exception is made of master keys, which are ordered direct from the maker, and do not go through the local locksmith. Under a system such as described here there is a minimum amount of laxity in the handling of large numbers of keys.

A typical 3 by 5-inch card drawer with an inside length of fifteen inches will easily hold 130 envelopes containing typical flat locker keys or sixty envelopes containing from one to four duplicates, each of typical cylinder lock or bit lock keys.

Managers of institutions who are planning to open new buildings should give advance consideration to the numbering of the rooms. While this may seem an unimportant detail, the building superintendent will be greatly helped if this is done on a consistent plan. I have in mind one of the main buildings of a prominent institution in which the southwest corner rooms on three successive floors each bear a different number. In the writing of maintenance orders and in other ways it is most helpful if typical rooms on all floors are numbered alike.

A study of all floors should be made and a numbering system worked out, based on the floor having the largest number of rooms and doors, when the building is being prepared for opening. The system should, when possible, start at some definite point, such as the entrance from a stair well, which is common to all floors, and should be arranged so all typical rooms on each floor bear the same numbers. Numbers should be skipped on floors with fewer rooms and doors. Connecting or closet doors should be separately identified with individual numbers. A good plan is to use the number of the room itself and then add an alphabetical letter. The occupants of a building are frequently vague in describing rooms and doors that need attention, but if each door bears a number requests for repairs can be taken care of promptly by the carpenter without the risk of his taking off the lock of the wrong door and sending it out for repairs, or to have a key fitted. One experience of this kind is sufficient to prove the desirability of thoughtful planning in this respect.

Efficient Ways to Handle Passenger Elevator Traffic

Safety in elevator operation depends to a large extent upon the proper training of the elevator operator. The following practical rules for elevator operators are posted in the elevators of a large building in Minneapolis and have produced good results.

Rules for Elevator Operators

1. Be sure the gates or doors are closed and latched and that everybody and everything is in safe position before you start the elevator. Better a delay than an accident.
2. Always remember the safety capacity of your elevator and never allow it to be overloaded.
3. Bring the elevator to a full stop before you attempt to reverse its direction. Start the car slowly.
4. Be sure to center (place in a neutral position) your hand rope, lever, wheel or switch controller; and wait until the car has come to a full stop before you open the doors or gates.
5. Do not try to show off by speeding your elevator.

Watch the speed carefully when going down, as a heavy load may increase your speed.

6. Learn the emergency call and get to the floor from which the call came as quickly as possible.

7. If the elevator does not operate properly for any reason, do not attempt to run it. Notify your superior at once.

8. If the safety device should operate and stop the elevator, do not attempt to start the car. Send for your superior immediately. If the elevator should stop between the floors keep cool and do not allow anyone to leave the car.

9. Do not permit unauthorized persons to operate the elevator.

10. Never leave the elevator unattended unless the car is empty and the doors or gates are closed and latched.

11. Be careful to stop the elevator level with the landing floor. If you have failed to do so give the warning by saying "Step up, please," or "Step down, please," as the case may be. Never attempt to correct a bad landing by moving the car after the doors or gates are opened.

12. Fooling, scuffling, or horseplay are prohibited in elevators. Require passengers to face the doors or gates, and do not allow them to enter the car until those who desire to get off have left.

Piping Change Cuts Hospital's Fuel Bill \$2,300

BY MAKING changes in the arrangement of the steam piping and installing a special engine considerable economies in the use of steam have been realized at the Beth Israel Hospital, Boston; the \$750 spent for piping has reduced the annual cost of fuel some \$2,300. The annual fuel cost before the change was \$15,300; after, \$13,000. This work is a good example of what has been accomplished in plants, buildings and institutions during the past two or three years toward cutting costs.

The hospital is a group of five buildings served with steam for heating and for equipment, such as autoclaves, sterilizing apparatus and cooking. Steam required for heating the hospital ranges from 7,000 to 13,000 pounds per hour, depending on the weather. About 2,000 pounds of steam per hour is the high-pressure requirement. Service was formerly by means of two 6-inch steam lines operating at 85 pounds pressure with a reducing valve at each building. These reduced the pressure to 3 to 4 pounds for distribution and utilization, except for those services requiring high-pressure steam.

Fuel Saving Is Due to Several Factors

The changes made were extremely simple. A new high-pressure steam line was installed to supply the autoclaves, sterilizers and kitchen equipment. The reducing valves at the five buildings were removed from the original steam lines and a large-diaphragm combination reducing valve was installed in each of the two 6-inch steam mains, at the power house; these reduce the steam for heating from 130 to $\frac{1}{2}$ -1 pound, according to the weather. All regulating is done at this one point, where close supervision and control may be exercised.

The fuel saving is due to a number of factors. Overheating of the buildings has been reduced by varying the steam pressure, depending on the outside temperature; in warm weather only 6 ounces is used. The improved means of regulation of the reducing valves at a central point is an important aid in reducing waste. Before, it was necessary to go to each of the five buildings when adjustments were called for at the reducing valves; under such conditions there was less efficient con-

trol. The maintenance of these valves is now less costly. With the low-pressure system it is possible to use the exhaust steam from the pumps which formerly was wasted. These exhausts are now connected with the high-pressure returns from the sterilizers, autoclaves and similar equipment.

How the Special Engine Operates

The special engine was installed several months ago in order to make as much use of the reduction in the boiler pressure as possible. The complete cost (including switchboard, circulating pumps, etc.) was \$13,000 and the power bill has been cut from \$1,100 to \$500, or \$600 a month. It is a three-cylinder vertical engine, direct connected to a 100-kilowatt, 400-r.p.m. generator which supplies electrical power for the whole establishment. The generator is run in phase with the utility system so that when requirements exceed its capacity the excess is automatically supplied from outside. Ordinarily the local generating unit is sufficient.

Except in winter the engine takes the place of the reducing valves. When it does not supply sufficient steam to keep up the pressure required adequately to heat the buildings, the deficiency is made up automatically by the reducing valves, which admit steam to the lines direct from the boilers.

In the summer the exhaust from the engine is used for heating the hot water supply for general use, for the kitchen, laundry, operating room and other services. Little exhaust steam is wasted even during warm months.

Layout Is Simple and Flexible

The manner in which the reducing valves, the high-pressure steam line and exhaust from the engine, as well as the low-pressure steam lines, are arranged makes it possible for either of the reducing valves to feed either or both low-pressure lines, or for either or both low-pressure lines to be fed from the engine. The lines can be fed from the engine alone, from the boilers alone or from both. This layout is simple and yet permits of complete flexibility in operation.¹

¹Reprinted from Heating, Piping and Air Conditioning.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by ANNA E. BOLLER, Central Free Dispensary at Rush Medical College, Chicago

Helping the Diabetic Patient to Help Himself

By DOROTHY E. FLITCROFT

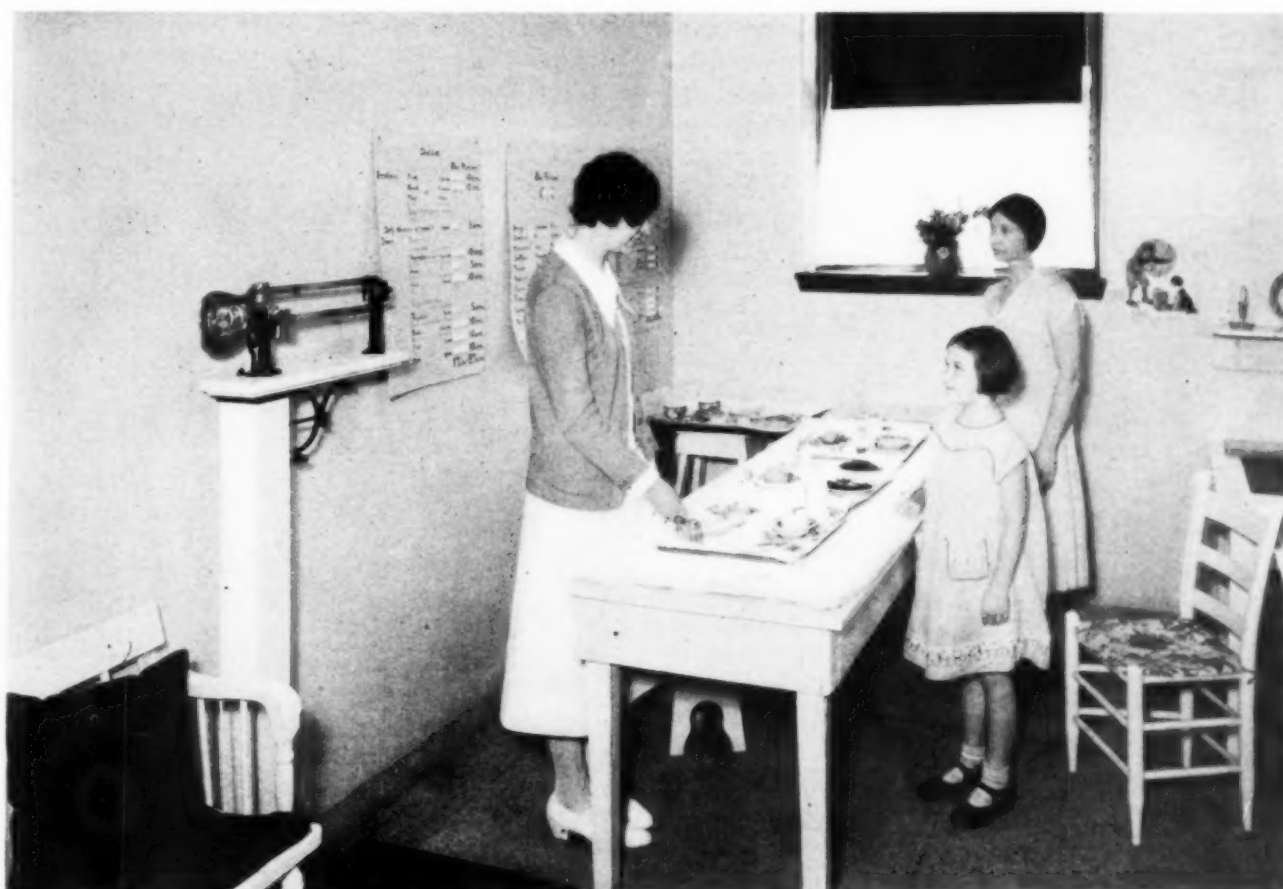
Dietitian, Paterson General Hospital, Paterson, N. J.

THE diabetic clinic in the Paterson General Hospital, Paterson, N. J., came into existence three years ago in response to the need of ward diabetic patients for continuous care after they had left the hospital. It also frequently happens that difficult clinic patients are referred to the diabetic ward for treatment. The close

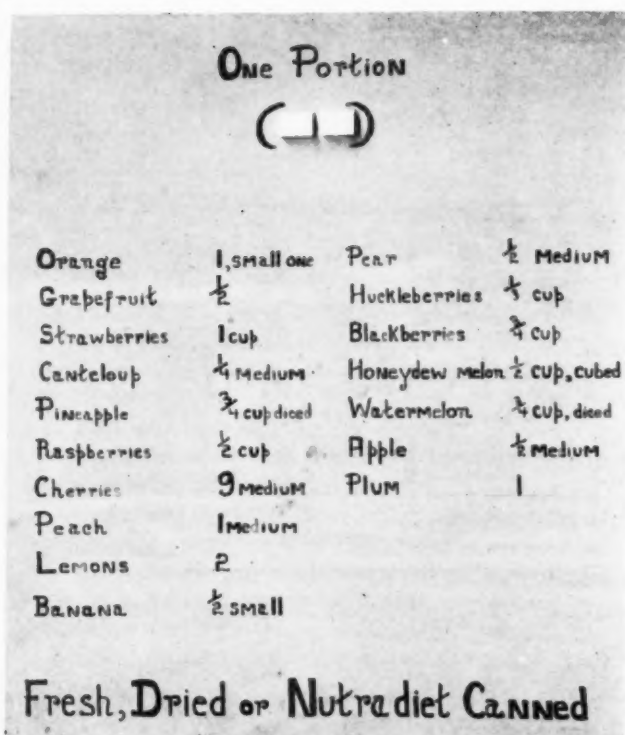
linking of ward and clinic work tends to reenforce the latter and helps to create a nucleus of the more cooperative cases.

It is these interested patients whose questions give the dietitian a view of the problem of diabetes as it appears to the patient.

During the first year of the clinic's existence



The patients select their own diet from a varied assortment of foods, guided by the diet list on the wall.



This poster lists the correct household measure for fruits, each portion equals two lumps of sugar.

an attempt was made to use the cheaper commercial products. For many reasons, this was found impractical, and, with the growing trend toward the higher carbohydrate diets, unnecessary.

Experience with clinic patients indicates that the majority of cases fall into one of three groups—those requiring carbohydrate 65, 85 and 100. There are exceptional patients who for a relatively brief period need a diet as low as carbohydrate 40 or 50, and there are mild cases who can get along on 120 or 140. Diet orders for these were originally given by the physician in

charge. Diet prescriptions further indicated total calories in each case, but did not specify actual grams of protein and fat, making these somewhat flexible. The carbohydrate value of any diet order represents some multiple of five. This makes possible the present system. The teaching material while applicable to diets over 100, has for its particular objective the three—65, 85 and 100.

Three outstanding features characterize this group—(1) the general plan of a normal diet; (2) standardization of portions; (3) variety obtainable through use of equivalents.

It is evident that this does follow in a general way the plan of a normal diet.

Posters Used for Instruction Purposes

The standardization of portions resolves itself into measuring with household measures the following essential items or units: oatmeal, bread, milk, vegetables and fruit. The first three of these are fixed factors whenever they appear on a diet and are not subject to change. The patient is encouraged to think of 3 tablespoons of oatmeal as one portion and it invariably appears in that amount on a diet list. Bread is thought of as one-half slice, and milk as one glass. These household measures tend to be slightly under rather than entirely up to the calculated amount. Each portion of oatmeal, bread or milk is equal, with only slight variation, to 10 grams of carbohydrate. On an accompanying sheet vegetables are listed in amounts roughly equaling 5 grams of carbohydrate and fruits are listed in amounts equaling 10 grams of carbohydrate. The list is taken with slight modification from Rudy's "Practical Handbook for Diabetic Patients."

It appears then that the carbohydrate values of individual items in any of the diets amount to

CARBOHYDRATE 100 DIET

Breakfast	Dinner	Supper
Fruit—1 portion	Clear broth	Eggs—two, or
Oatmeal—3 tablespoons	Lean meat—average serving	Cold sliced meat—average serving,
Toast—1/2 slice	Vegetables—2 portions	or
Butter—average serving	Butter—2 teaspoons	Cheese—2 tablespoons, or
Eggs—two or one egg and	Bread—1/2 slice	Fish (plain, no sauce)—average
bacon—3 strips	Butter—average serving	serving
Coffee	Fruit—1 portion	Vegetable (cooked) or as salad—
Daily allowance of light	Tea (with cream or top milk	1 portion
cream, or top milk—1/2	from daily allowance)	Butter, mayonnaise or oil—2 tea-
glass		spoons
		Bread—1/2 thin slice
		Butter—average serving
		Fruit—1 portion
		Milk—1 glass
		Tea (with cream or top milk from
		daily allowance)

either 5 or 10 grams. Borrowing Doctor Joslin's idea of illustrating the value of different carbohydrate foods through the use of cubes of sugar, such a list as the one above, suggests a poster having printed on it a diet list on which opposite the carbohydrate foods their actual value is given in either one or two cubes of sugar, one cube actually weighing 5 grams. Hence we procured a large sheet of pale yellow cardboard and on it printed the actual food list of a carbohydrate 65 diet, green paint being used for carbohydrate foods and lavender paint for protein and fat foods. Cubes of sugar were attached by means of

glucose. Such posters as these tend to correct the erroneous idea frequently found to exist among clinic patients, namely, that a diabetic diet does not contain any sugar, and therefore they can take all they wish of the foods listed. It has also been found that visual imagery makes a more lasting impression than information given by word of mouth. What a patient sees makes a more lasting impression than what he hears. Again, it is valuable to be able to point to a list on the wall and say to the patient, "This is *your* diet." He learns that there are differences in diabetic diets. He can distinguish between the diet he gets and



The diabetic clinic in the Paterson General Hospital, Paterson, N. J., is fully equipped for its work.

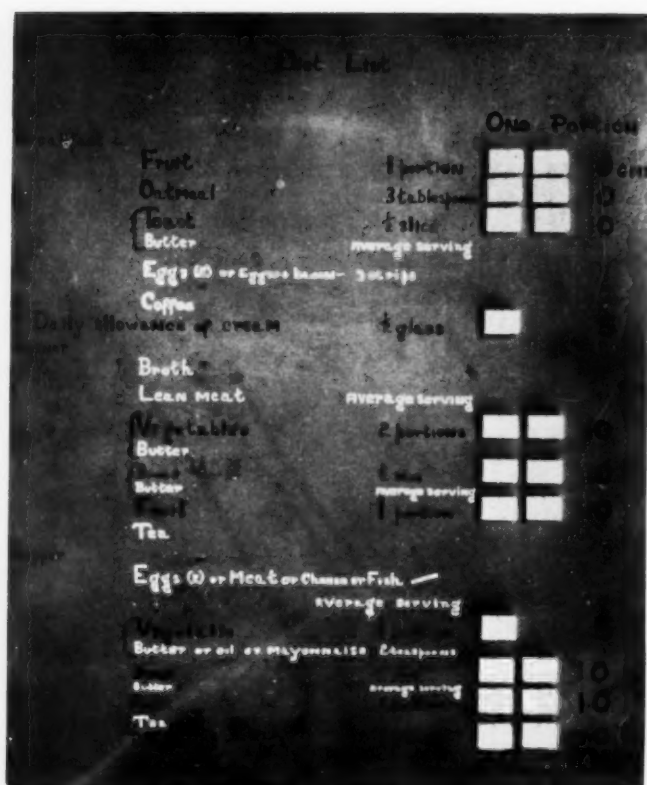
surgical catgut. Altogether three such posters were made, one for a carbohydrate 65 diet, one for a carbohydrate 85 diet and one for a carbohydrate 100 diet. In addition, one other poster was made listing the correct household measure of one portion of fruit. Since these are all equivalent to ten grams of sugar, two cubes are attached.

These four posters are displayed for patients to see when they come to the clinic. This has three effects, first, to cause patients to ask questions, second to make them realize that their diets do actually contain sugar, third, to make them understand which foods contain the sugar. Needless to say, no attempt has been made to account for total

the one his neighbor gets, owing to difference in degree of diabetes. This helps him to realize the importance of following his own diet instead of his neighbor's.

From one-half to three-quarters of an hour of the time devoted to the clinic is taken up with teaching, which starts at about 2:30 p.m., and lasts until about 3:15, when the clinic starts.

This arrangement simplifies the question of diets for the patient but does not tell the whole story of diabetes. The patient is further interested to know "what it's all about" and to this end the first of a series of seven lectures is prepared to tell the patient in simple terms just what



The poster used for a carbohydrate 100 diet.

diabetes is, what organ of the body is affected, what sugar tolerance is and what is meant by sugar threshold. Pictorial posters are under way to illustrate what is meant by tolerance and threshold. The remaining six lectures are really not lectures at all, but explanations and lessons illustrated by posters and demonstration trays. The lectures cover the following subjects:

Lessons Given on Different Subjects

1. What Diabetes Is—(a) tolerance; (b) threshold; (c) classification of foods. Pictorial posters are in process of being made, to illustrate these points.

2. Fruits—one portion. Illustrative posters are used and the patient actually measures one portion of different fruits, under supervision. Fruits are discussed as sources of minerals and vitamins.

3. Vegetables—one portion. The patient measures one portion each of several different vegetables, under supervision. The patient is told in popular language about the value of vegetables as sources of minerals and vitamins.

4. The patient selects his diet. (a) A food truck placed at one end of a long table contains various items needed to make up any of the diet lists; (b) Three empty trays are placed in order on a long table; (c) The patient reads the list from the chart on the wall; (d) The patient, following his list, selects items from the truck and

the dietitian, at the patient's direction, sets up his breakfast, dinner and supper trays.

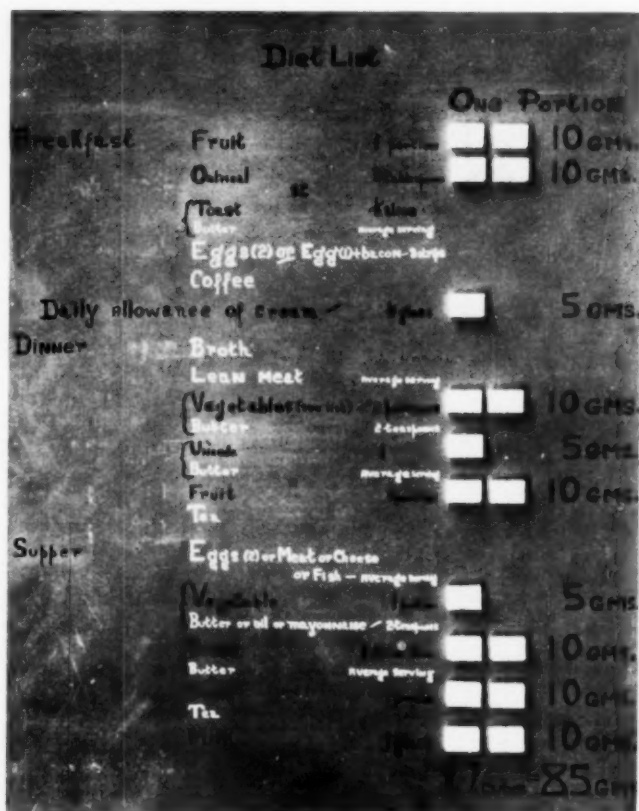
5. Recipes—noon meats, prepared with vegetables. (a) Recipes are labeled one portion or two portions, according to their carbohydrate content. This makes possible ready substitution. (b) Demonstration trays show recipes made up. (c) The patient practices setting up his own dinner tray.

6. Recipes—desserts, not exceeding 10 grams of carbohydrate. These may be substituted for one portion of fruit. Many of these recipes are taken directly or with slight variation from "Food for the Diabetic," by M. P. Huddleson. (a) Demonstration trays are set up, labeled with cardboard signs in white with black lettering. (b) Desserts are grouped according to ingredients and show different stages of preparation.

7. Recipes—supper main dishes, substitutes for two eggs and one portion of vegetable. (a) Demonstration trays show completed recipes. (b) The patient practices setting up his supper tray, making substitution from chart on wall.

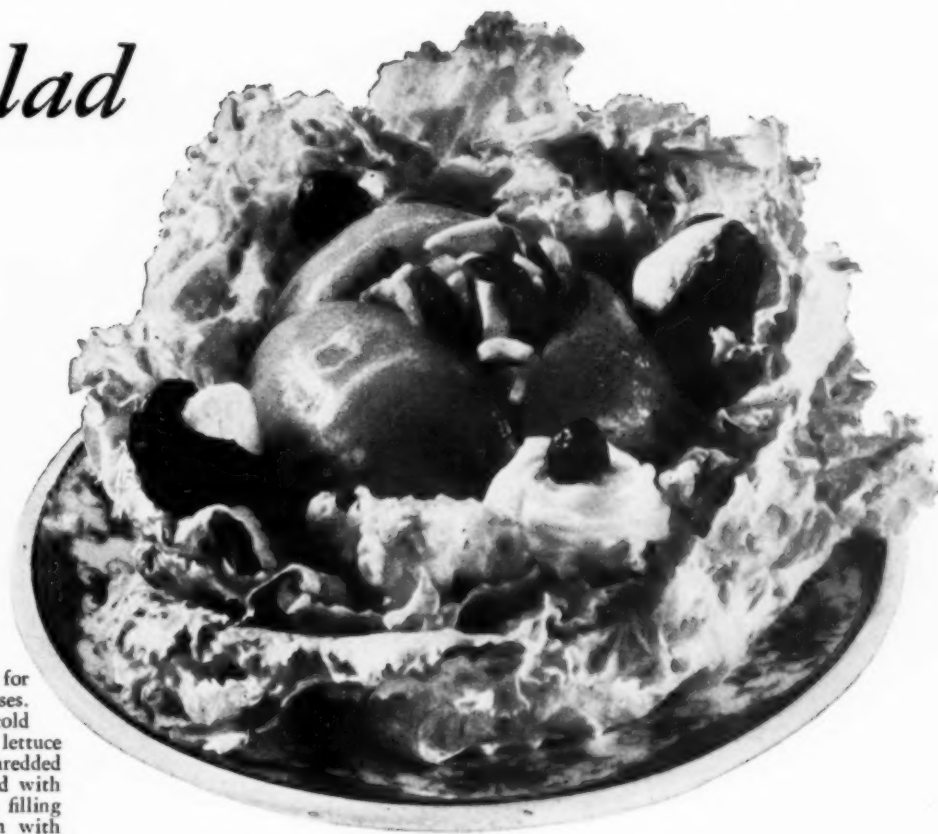
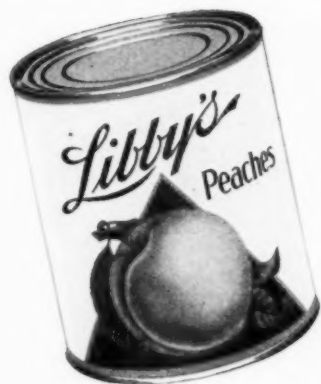
The lectures are self-explanatory, but the following points are important and should be carefully noted.

The lectures attempt to follow the patient's natural trend of thought in logical successive steps. The first question asked is, "What Is Dia-



The poster used for a carbohydrate 85 diet.

Esther Fisher of San Francisco's ST. FRANCIS HOSPITAL *finds convalescents welcome this Peach Salad*



Miss Fisher suggests Stuffed Peach Salad for light and general diets, also for anemia cases. Recipe: Arrange crisp lettuce leaves on a cold salad plate. Upon a small pile of shredded lettuce place a filling of shredded pineapple, shredded almonds and a few chopped dates, topped with chopped maraschino cherries. Around filling arrange 3 Libby Peach Halves. Garnish with rosettes of mayonnaise, and 2 dates stuffed with marshmallows.



These Libby Foods of finest flavor are now packed in regular and special sizes for institutions:

Red Raspberries	Beef Extract
Tomato Purée	Peas, Catchup
Corn, Beets	Chili Sauce, Salmon
Hawaiian Pineapple	Evaporated Milk
California Fruits	Mince Meat
Spinach, Kraut	Boneless Chicken
Jams, Jellies	Stringless Beans
Pork and Beans	Santa Clara Prunes
Tomato Juice	in Syrup
Olives, Pickles	Strawberries
Mustard	Loganberries
Bouillon Cubes	California Asparagus

AS every dietitian and doctor knows, it's mighty important that patients should enjoy their meals. Appetite unquestionably aids in the digestion of foods.

That is one reason why the Peach Salad pictured here frequently figures in convalescent menus planned by Esther Fisher, Chief Dietitian of the St. Francis Hospital in San Francisco.

Another reason is economy. For the ingredients of the salad are simple and inexpensive. But it is given an air and a special attrac-

tiveness by the use of Libby's California Peaches.

These Peaches are not only sun-ripened and unusually delicious, but in every can the halves are superbly matched for size, shape, color, flavor, texture. No wonder salads made with them have charm!

Yet in spite of the extra care taken in selecting and packing them, Libby's California Peaches cost no more than ordinary brands. So make it *Libby's* when you order. You can get them from your usual source of supply.

Libby, McNeill & Libby
Dept. N-41, Welfare Bldg., Chicago

betes?" and the next, "What Foods May I Eat?" "How Much?" "How Do I Vary Them?" Hence, Lesson 1 tells the patient what diabetes is; 2 and 3 are devoted to the standardization of portion; 4 shows him how to select his own diet, and 5, 6 and 7 tell him how to vary it.

In addition to the advantage of visual imagery in poster work, it has been found effective to have portions standardized. It has been observed repeatedly that patients have a natural tendency to associate a certain food with a definite amount. The standardization of portions utilizes this fact, so that to a clinic patient the term apple signifies one-half medium apple.

It is an advantage to have patients measure

portions of vegetables and fruits and select their diets under supervision in the clinic. This process tends to emphasize the essential points taught and renders them more effective.

Since our Italian patients form a sizable group, we have arranged for an Italian physician to give Lesson 1 in Italian. The patients appreciate this. Diets are translated into Italian and mimeographed sheets are available for the patients. This is true also of simplified material on diabetic hygiene and directions to patients for the proper use of insulin.

The clinic's steady growth has brought the total enrollment to approximately 200, with an average attendance of approximately twenty persons.

How Social Data Are Filed With Medical Histories

As the value of medical social service becomes increasingly apparent in the medical care of the patient the need of making pertinent social data readily available to the doctor treating the case is assuming a place of greater prominence in the thinking of medical social workers, according to Mary Wysor Keefer, U. S. Naval Hospital, San Diego, Calif.

In the year 1930-31, the American Association of Hospital Social Workers made a study of prevailing practices of filing social data in medical cases in different hospitals. Questionnaires were mailed to 387 medical social service departments.

From the 250 replies received, the following conclusions were drawn concerning current practices in recording social data with medical histories:

1. Seventy-two per cent of these departments are filing social data in medical histories, such recording varying all the way from bare financial investigations to the entire social history incorporated in a unit medical-social record.
2. The most usual way of filing such information is by means of the social summary, this method outnumbering notes directly on the medical record about two and one-half times. Approximately the same number that use notes on the medical history use a combination of both methods.
3. There is often a difference in practice in social recording between the work on the wards and the out-patient department of the same hospital. It is more unusual to find social history filed in medical histories in the out-patient department and not in the wards than vice versa. Where a combination of the two methods is found the social summary is more often used on the wards and notes on medical history in the out-patient department. About 30 per cent of the departments filing information in medical histories do so only on certain wards or on selected cases.
4. Almost twice as many departments use a definite outline for their records as those who do not.
5. Usually there is no special place accorded the social data in the medical history but it is most often included in the medical examination and history or entered chronologically.
6. Almost every department recording social data in medical histories has found the practice has resulted in a

more satisfactory relationship with doctors and hospital, and more effective service to the patient. There is a decided belief, however, that the verbal report must be combined with the written one.

7. The most usual reasons for not filing social data in medical histories are insufficient staff; inconvenience; opposition from doctors or hospital authorities, and the confidential nature of social information.

Mechanical vs. Hand Methods of Vegetable Preparation

A study of the comparative cost of the preparation of vegetables by machine and by hand in institutions, by Helen A. Goodenow, develops some helpful suggestions.

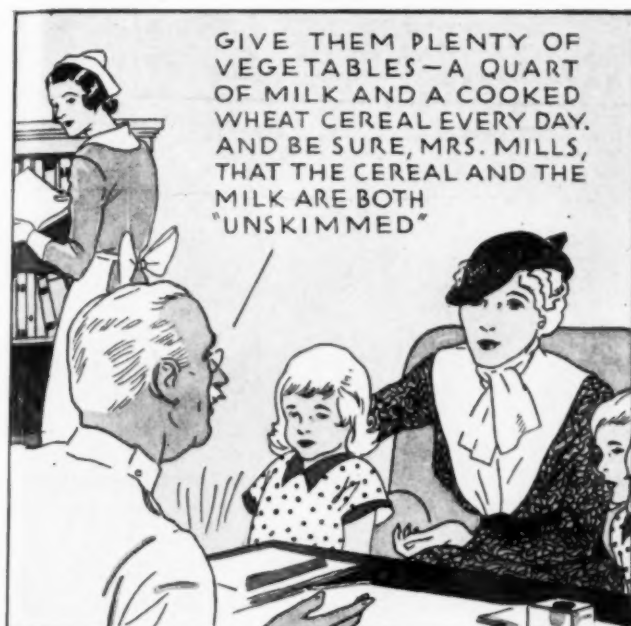
The conclusions are based on a study of eleven institutions in Seattle, Wash., including a university cafeteria, two university dormitories, an industrial cafeteria, two high school cafeterias, two of the largest hotels of the city and three hospitals of 100, 180 and 300 beds each. The Seattle study showed that if an institution is of moderate size or larger, most labor saving equipment for vegetable preparation does pay for itself.

Equipping the kitchen with labor saving devices for vegetable preparation may result in the investment of a large sum of money. Such equipment must effect economies in labor or vegetables to give a profit. The depreciation rate is usually estimated as 10 per cent, but the equipment may last longer than ten years if given good care.

The saving in labor on potato, carrot and turnip peeling done by machine is sufficiently large to enable the institution using a moderate amount of these vegetables to save the price of a machine in a comparatively short time.

The chopping machine prepares the vegetable with extreme rapidity and is most useful for purposes such as preparing soup material where appearance is not an important factor. A good appearance in salad material, however, is essential, and it is therefore considered better to chop it by the hand method which yields a more sightly product. The purchase of a chopper should not depend alone upon its use for vegetables as it may also be used for many other foods.

A slicing machine is an economical investment where many sliced cucumbers are used. Cabbage and lettuce shredding with a machine is not desirable.



Do you know as much about cereals as you do about milk?



Cereals are like milk in one important respect. To provide full food value both must be "unskimmed." Just as milk is deprived of important elements when cream is skimmed off—wheat cereal is deprived of valuable body-building properties when one or more of the three parts of the wheat grain are skimmed off in manufacture.

These Three Parts are:

1. **BROWN** (bran) containing generous quantities of phosphorus and iron—proteins of exceptionally good quality.
 2. **WHITE** (endosperm) a good source of carbohydrates for warmth and energy.
 3. **YELLOW** (embryo) one of the richest sources of the anti-neuritic, appetite-stimulating vitamin B.
- Be sure the cereal you recommend is unskimmed. Ralston contains the tiny brown, white and yellow particles. It is unskimmed.



Ralston Wheat Cereal is "UNSKIMMED"

It is Richer than Whole Wheat

RALSTON contains the valuable inner bran layers, the endosperm and embryo of whole wheat—without the coarse outer bran layers. In addition, it contains two and one-half times the amount of vitamin B—rich embryo normally found in whole wheat. Ralston has not been subjected to vitamin-destroying heat processes.



A supply of Ralston Wheat Cereal for testing—samples suitable for distribution among patients, and a Laboratory Research Report, will be sent to you without cost. Fill in the coupon below and mail to

RALSTON PURINA COMPANY
473 Checkerboard Square, St. Louis, Mo.

Send me material as offered in your advertisement.

Name

Street

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This offer limited to residents of the United States.

NEWS OF THE MONTH

Greater Operating Economy Is Goal of Pennsylvania Hospitals

"CARRYING ON" under present economic conditions was the keynote of the conference of the Hospital Association of Pennsylvania, held March 21 to 23 in Philadelphia. More economical operation; handling cases with overcrowded facilities; treatment of tuberculous patients by the general hospital; utilizing unoccupied private rooms; discontinued of free hospitalization to war veterans for disabilities incurred since the war; group practice, and selling the hospital to the public were among the many subjects which afforded approximately 300 hospital executives in attendance much food for thought and study.

The three-day session during which well chosen addresses were interspersed with constructive round table discussion held something of interest for every type of hospital executive present. The presence, too, of approximately fifty exhibits, ranging all the way from orange juice to the latest type of oxygen tent, proved a noteworthy educational feature. Good fellowship was stimulated by the annual dinner held Wednesday evening when members and their guests were invited to enjoy a particularly successful program arranged by John M. Smith, superintendent, Hahnemann Hospital, Philadelphia, president of the association, and Howard E. Bishop, superintendent, Robert Packer Hospital, Sayre, Pa., executive secretary, with Dr. S. S. Goldwater, New York City, occupying the position of honor as chief speaker.

Members of the association were welcomed at the opening session by Philip Gadsen, president, Philadelphia Chamber of Commerce, who emphasized the increasing burdens placed upon hospitals by the depression.

Effects of Depression Described

This point was also emphasized by Melvin L. Sutley, president, Philadelphia Hospital Association, who referred to the rapidly diminishing donations that were compelling many hospitals to curtail their free work.

With the general keynote of the convention thus sounded, the representatives were better prepared the following morning to hear Miss K. Frances Cleave, nursing consultant, department of welfare, Commonwealth of Pennsylvania, describe how the hospitals of Pennsylvania are meeting their nursing problems. This session, which was presided over by R. W. Froberger, assistant superintendent, George F. Geisinger Memorial Hospital, Danville, Pa., also included an address by President Smith in which he traced the effects of the depression upon the hospitals.

Two round table discussions occupied the visitors during the afternoon, one being conducted by Esther J. Tinsley, superintendent, Pittston Hospital, Pittston, Pa., and the other by Dr. Donald C. Smelzer, director, Graduate Hospital of the University of Pennsylvania, Philadelphia.

Professional cares were laid aside, temporarily at least,

for the evening of March 22, when members of the association assembled for the annual dinner. Gracious tributes to various outstanding figures in the hospital field were made by President Smith in the course of which he introduced Dr. Nathaniel W. Faxon, president-elect, American Hospital Association. The feature of the scheduled program was the address by Doctor Goldwater, "The Hospital, the Family Doctor and the Patient," which appears in full on page 41.

The last day of the meeting proved a busy one with two sessions crowded with interesting talks and ensuing discussions. Doctor Smelzer was in charge during the morning, introducing the various speakers. Here again, the subjects bore upon economy in hospital operation.

Doris L. Dungan, executive housekeeper, Jeanes Hospital, Fox Chase, Pa., gave many practical hints on the proper maintenance of floors and walls, also how to purchase and launder bed linens and blankets. For example, it is Mrs. Dungan's opinion that a blanket of 50 per cent wool and 50 per cent cotton is a better investment than one made of cheap wool.

That the art of cooking is as important as the art of surgery was the thought advanced by Helen E. Gilson, director, dietary department, Pennsylvania Hospital. Miss Gilson stated that the small hospital requires just as thoroughly trained a dietitian as larger institutions.

Arthur A. Fleisher, president, board of trustees, Jewish Hospital Association, described the attitude of the patient entering a hospital for the first time, and stressed the need for putting him at his ease and eliminating his fears.

An outstanding feature of the afternoon session was a discussion of the hospital service plan used in Essex County, New Jersey. This was described by Dr. Paul Keller, executive director, Newark Beth Israel Hospital, Newark.

Jessie J. Turnbull, superintendent, Elizabeth Steel Magee Hospital, Pittsburgh, was elected president of the association, and Charles A. Gill, superintendent, Protestant Episcopal Hospital, Philadelphia, president-elect. Howard E. Bishop continues as executive secretary.

Convention of Texas Hospital Group Largest in Its History

The Hospital Association of the State of Texas held its fourth annual convention at Dallas, March 17 and 18, with representatives from more than 100 hospitals in attendance. Approximately 200 delegates were registered, and the convention was the largest in the association's history.

Dr. J. H. Stephenson, superintendent, Parkland Hospital,

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SEND FOR THIS PAMPHLET

"The Use of Insulin in Non-Diabetic Malnutrition"

Physicians are invited to write for a pamphlet containing terse abstracts of some of the important publications on this subject. The text gives brief consideration to the mechanism and physiologic significance of carbohydrate metabolism in general; the use of Insulin in malnutrition of infants, children, and adults; and the Insulin dosage suggested.



PROMPT ATTENTION GIVEN TO INQUIRIES FROM PHYSICIANS

ADDRESS ELI LILLY AND COMPANY, INDIANAPOLIS, INDIANA, U. S. A

NEWS OF THE MONTH (Cont'd)

Dallas, was elected president of the association for the ensuing year, and Bryce L. Twitty, Baylor University Hospital, Dallas, president-elect.

Group hospitalization came in for considerable discussion. Dr. J. H. Groseclose, superintendent, Dallas Methodist Hospital, Dallas, presented a paper on group hospitalization as operated by an individual hospital, while group hospitalization as operated by a group of hospitals was discussed in a paper presented by Martha P. Robertson, superintendent, Medical and Surgical Hospital, San Antonio. Robert Jolly conducted a round table on group hospitalization.

The Friday afternoon session was devoted mainly to a discussion of Texas hospital laws and legislative procedure. The remainder of the afternoon was given over to the subject of nursing.

It developed in the ensuing round table discussion that a number of hospitals of less than 100 beds had discontinued their training schools and were employing graduate nurses. In every case but one where such a change had been made the superintendents were convinced that the exclusive graduate system gave better service at less cost.

Dr. Bert W. Caldwell, executive secretary, American Hospital Association, and Michael M. Davis, director for medical services, Julius Rosenwald Fund, Chicago, were the principal speakers at the annual banquet. Doctor Caldwell spoke on public relations, and Doctor Davis discussed the future of hospitals in the practice of medicine.

Dr. Lucius R. Wilson, superintendent, John Sealy Hospital, Galveston, gave an interesting talk on Saturday on what the Texas hospitals are doing about sick leaves, vacations and employees' discounts. Miss Brient spoke on "Reducing Hospital Expenses—Increasing Incomes."

Hospital Reference Book Is Published

A reference book giving historical, statistical and other information on the accredited hospitals and allied institutions of the United States and Canada has recently been published by the Midwest Publishers Company, Minneapolis, under the title "American and Canadian Hospitals." The book was edited by James Clark Fifield with the cooperation of the American Hospital Association. It is dedicated to the late Eugene Stuart Gilmore, for many years superintendent, Wesley Memorial Hospital, Chicago.

The foreword states that the volume contains a description of practically every reputable hospital in the United States and Canada. Each sketch includes a brief history of the institution, fiscal data and personnel arrangements.

The first part of the book presents articles prepared by leaders in the hospital field giving the histories of all the national organizations in the field. The appendix is an interesting feature and contains histories of all the religious orders in the field, information pertaining to important endowments and funds devoted to the improvement of health and other pertinent facts.

The book is set in clear readable type and contains over 1,500 pages. The price is \$10.

Colorado Appoints Committee on Nursing Education

The spring meeting of the Colorado Hospital Association was held at Mercy Hospital, Denver, on March 16. The speakers were Dr. C. F. Kemper, Denver, and F. D. Bramhall, University of Colorado, both of whom talked on the report of the Committee on the Costs of Medical Care.

At the business meeting, Frank J. Walter, superintendent, St. Luke's Hospital, Denver, president of the association, reported on the February meeting of presidents and secretaries of regional and state hospital associations.

The association voted to establish a committee of nine members, to be known as the Committee on Nursing Education. The duties of this committee will be to initiate, under the guidance and with the authority of the association, such activities in the field of nursing as may from time to time be found necessary for the safeguarding of the interests of hospital schools of nursing in the progressive development of nursing education.

New York Hospital Opens New Pavilion; Scope Widened

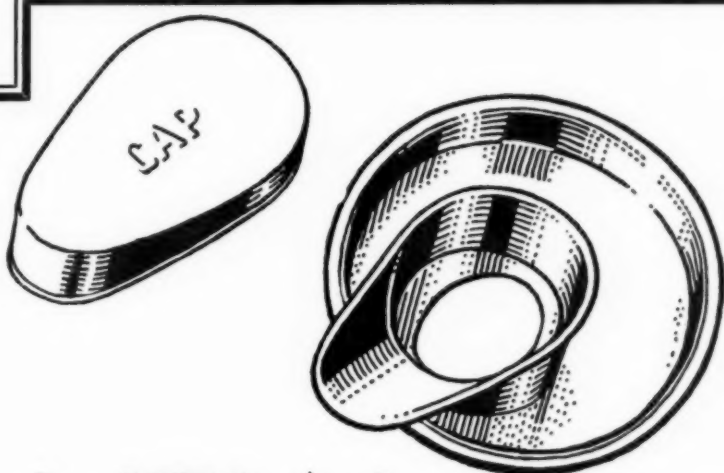
A new thirty-bed pavilion was opened March 13 on the ninth floor of the New York Hospital-Cornell Medical Center, New York City, and by this measure members of the board of governors of the institution believe they have solved difficulties which came to a head last December when fourteen part-time surgeons, all members of the attending staff, protested that since the merging of the hospital with the medical school in September most of the ward operations had been performed by the full-time resident staff.

The new beds will be available solely for patients of attending surgeons or those recommended to the surgeons by friends of the medical profession. For the present, at least, surgical operations will be performed in the rooms used by the full-time surgeons. Twenty of the new beds will be for general purposes, while the remaining ten beds will be for urologic cases.

Previously, members of the part-time staff were permitted to operate only in the private rooms in the upper stories of the hospital.

In the offices of John R. Howard, Jr., superintendent, it was said: "This is the first step taken in the general hospital to enlarge the services which were curtailed, because of decreased income due to the depression, at the time the new building was opened last September." The new pavilion raises the number of all surgical beds to 176, a total which includes 136 devoted to general surgery.

The present move does not constitute a change in the original plans of the hospital, it was pointed out, and practical training will still be given postgraduates of the medical school. It denotes, however, a further carrying out of the plans so as to permit more actual work by surgeons with private practice.



This new pouring spout converts the KARO can into a practical syrup pitcher with protective cap.

NEW...for convenience...for accurate measurement...for greater hygienic protection of KARO babies

IN keeping with the progressive policy of the makers of KARO Syrup, this new KARO pouring spout has been devised (1) to further safeguard the purity of KARO Syrup, (2) to make the measuring of KARO more accurate and convenient, (3) to provide insurance against contamination.

Your patients will be glad to know about this new feature. Despite the

costliness of the new spout, the price of KARO remains the same.

The KARO pouring spout may be obtained without cost by addressing the manufacturer.

Year after year, KARO enjoys greater acceptance by the medical profession. Its value as a practical carbohydrate in the modification of milk for infant feeding is now universally recognized.



FREE TO PHYSICIANS

KARO prescription blanks for whole milk, evaporated milk and acidified milk formulas will be provided free to physicians upon request. Write to Corn Products Refining Company, 17 Battery Place, New York City.

NEWS OF THE MONTH (Cont'd)

New York Hospital Group Protests Proposed Legislation

The Hospital Association of New York State has voiced a strong protest against the two bills now pending before the state senate, labeled No. 437 and No. 438. A letter explaining the association's stand and requesting cooperation in opposing the two bills has been mailed to the newspapers and to Governor H. H. Lehman. The letter is signed by Boris Fingerhood, president of the association, and superintendent, Israel-Zion Hospital, Brooklyn.

Bill No. 437 refers to the elimination of the nominal dispensary fee charged to patients, and Bill No. 438 to the creation of a central bureau under medical auspices for the purpose of determining the social status of prospective applicants for free treatment and the distribution of free treatment cards.

"The bill numbered 437, and intended to make illegal the charge of any fee whatsoever, would, if it were put into effect, have an appalling effect," the letter points out. "It is unfair both to the public and to the hospital. It represents an attempt to cure an economic problem by the creation of difficulties."

Concerning Bill No. 438, the letter says: "This attempt to create a central social service station under medical auspices is ineffectual in its ultimate application. At best, it represents a duplication of the work now going on, presuming that county medical, dental and pharmaceutical societies will be able, and have the means and ability, to organize and conduct such social agencies. It is also highly questionable whether these investigative agencies, functioning under the supervision of the medical, dental and pharmaceutical societies can possibly be as effective as the present social agencies which work in close collaboration with the hospitals and with one another and fully understand the existing routine."

Both of these measures, the letter states, show a complete disregard and misunderstanding of the medical and social problems as they exist today.

California Hospitals Prove Mettle in Earthquake Disaster

Reports from the California earthquake zone indicate that the hospitals of Long Beach and their associated staffs are receiving high commendation for the creditable manner in which they rendered service to the victims of the disaster. One hospital was completely deprived of its usefulness by the quake. A large section of another hospital was made unusable due to the caving in of the external walls. Water, gas, lights and telephone communication were cut off.

In spite of these handicaps the hospitals carried on using candles and lanterns. Approximately 1,000 victims were hospitalized in the first forty-eight hours in hospitals with a normal capacity of 500 patients. In addition, hundreds of victims with minor injuries were treated in temporary

out-patient departments. In many instances emergency treatment was given and the less seriously injured were removed to tents and other available accommodations.

The doctors of the various staffs set up emergency stations and out-patient services to care for the ambulatory cases. Public health organizations took charge of the sanitary problems and within twenty-four hours had these matters well in hand. Radio was the only means of outside communication by which needs could be made known. The various Los Angeles hospitals cooperated by providing supplies which otherwise could not be obtained. Nurses and doctors from unaffected areas responded to the radio calls and many of them arrived at the scene of the disaster within an hour after the quake.

Marines from the U. S. Navy squadron, which was in the harbor at the time, were landed immediately to patrol the city. Medical units from the hospital ship *Relief* contributed valuable service. Welfare organizations set up tents in the parks.

One of the greatest difficulties the hospitals encountered was to obtain laundry service, as their own water and gas were cut off. The hospitals in Los Angeles assumed this obligation and within twelve hours after leaving Long Beach the trucks that had taken the soiled linen to Los Angeles returned with a fresh supply.

Institutional members of the Western Hospital Association for a distance of 500 miles phoned the office of the association that they were prepared to render every assistance possible in the matter of personnel and supplies. The association office acted as a clearing house in obtaining the necessary supplies. Comparatively little assistance was needed, however, from outside sources.

International Hospital Congress Extends Invitation

The International Hospital Association has extended an invitation to all officials, associations, authorities and persons who are interested in the construction, organization and development of the hospital to attend the third International Hospital Congress, to be held at Knoeke, Belgium, June 28 to July 3.

"The world crisis has so strongly and clearly emphasized the tasks which the hospital has now to undertake that the necessity of exchanging information on experiences of the different countries and of putting important questions between them on a proper international understanding has made itself more and more felt," the association officers point out. The International Hospital Association will endeavor to meet this need at the forthcoming congress. It is the intention to make available at the congress the collected information and experiences of the ten international study committees of the association, for the further development of hospital work.

A five-day study tour through Holland will follow the congress. Those who make the tour will be shown not only the new hospitals, but the economic centers and the beauties of the Dutch landscape.

Besides economy...

these new-found reasons why

PINEAPPLE-CANNED

is advised for
daily use—



Quick, easy to prepare, and economical for hospital use. A Pineapple Cup of crushed or tidbits. Or two slices.

RECENT nutritional studies reveal these striking new discoveries about Canned Pineapple.

Already known as a good source of vitamins A, B and C, and as a digestive aid... it is now known to be one of our most valuable fruits, from many other angles.

It is shown to possess more essential nutritional values, and to meet more known dietetic needs, than any other fruit similarly studied. Note these new-found values in the panel at the right.

Based upon soundly established tests on human subjects—these

findings demonstrate the importance of Canned Pineapple for daily use. In general and childrens' diets. Also, prepared in various combinations, for some of the restricted, such as anti-constipation, obesity, anemia, and high-caloric diets.

And you will find that, for every portion, the cost is small.

Use Canned Pineapple not only in salads, mousses, with meats. But especially in these two easily prepared, economical forms—for appetizers and desserts. A Pineapple Cup of crushed or tidbits, or a serving of two slices.

Supplying all these essential values

1. Canned Pineapple is a generous source of vitamins A, B and C.

2. It furnishes the minerals that safeguard against nutritional anemia—iron, copper and manganese. And it supplies notable amounts of calcium and phosphorus.

3. It helps effectively to prevent acidosis by contributing to the normal alkalinity of the blood.

4. Canned Pineapple speeds digestion in the stomach of foods with which it is eaten.

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These statements are made only about Canned Pineapple, NOT the raw. The temperatures applied in canning cause a beneficial change of dietetic importance.

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PERSONALS

BENA M. HENDERSON has resigned, on account of ill health, as superintendent, Milwaukee Children's Hospital, Milwaukee. MISS HENDERSON came to Milwaukee Children's Hospital ten years ago after several years as superintendent, Children's Memorial Hospital, Chicago. She organized and opened the new hospital on Seventeenth Street.

DR. WILLIAM J. TIFFANY, formerly superintendent, Kings Park State Hospital, Kings Park, N. Y., is now superintendent, Pilgrim State Hospital, Brentwood, L. I.

T. F. ALEXANDER has been appointed superintendent, Tampa Municipal Hospital, Tampa, Fla., to succeed the late DR. ROBERT E. BALDWIN. MR. ALEXANDER served as a member of the hospital board during the commission form of government and later was superintendent of the institution. DENNIS MCGEACHEY has been serving as acting superintendent of the hospital.

DR. THOMAS F. HIGGINS has been appointed general superintendent, Lucas County Hospital Annex, Toledo, Ohio, succeeding GEORGE DEMUTH. CLARENCE BENEDICT has been named assistant superintendent of the institution.

SAIDEE N. HAUSMANN has succeeded HOMER C. HARRIS, resigned, as superintendent, Robert B. Green Memorial Hospital, San Antonio, Tex. For the last five years MRS. HAUSMANN has been director, school of nurses, St. Luke's Hospital, St. Louis.

MADGE HAMNETTE, superintendent, Children's Free Hospital, Louisville, Ky., has resigned, and is succeeded by ELSIE DELIN, formerly assistant superintendent of the institution.

DR. S. W. PAROWSKI has been appointed managing officer, Illinois Eye and Ear Infirmary, Chicago.

BLANCHE M. FULLER, formerly superintendent, Nebraska Methodist Episcopal Hospital, Omaha, Neb., is the new superintendent, Montana Deaconess Hospital, Great Falls, Mont. ALIDA M. JACOBSON is acting superintendent at the Nebraska Methodist Episcopal Hospital.

MARGARET R. LAWRENCE, formerly assistant superintendent, Montreal Foundling and Baby Hospital, Montreal, Que., has been named superintendent of the institution.

DR. ALBERT CHESANOW has been appointed superintendent, West Hudson Hospital, Arlington, N. J.

DR. W. G. PATTON has been appointed superintendent, St. Louis County Hospital, Clayton, Mo., succeeding ANNA BRAND, who served in that capacity for a short period following the death of DR. EUGENE A. SCHARFF, which occurred on January 11.

NELLIE MALONE has been appointed superintendent, Strathroy General Hospital, Strathroy, Ont.

SISTER MARY BERNADETTE, formerly superintendent of the surgical department, St. Joseph Mercy Hospital, Fort Dodge, Iowa, is now superintendent, Leila Y. Post-Montgomery Hospital, Battle Creek, Mich.

DR. ROBERT BURNS SANDERSON, for the past two and a half years assistant superintendent, Lake County Tuberculosis Sanatorium, Crown Point, Ind., has recently become superintendent and medical director, Healthwin Hospital, South Bend, Ind.

MYRTLE W. LITTLEJOHN has been named superintendent, Marlboro County General Hospital, Bennettsville, S. C.

DR. RALPH F. PALMER recently assumed the superintendency, Arizona State Hospital, Phoenix, Ariz., succeeding DR. K. D. CURTIS, temporary superintendent since the first of the year.

SISTER MARY BONIFACE SCHUM of the Sisters of Charity of Nazareth, died at the SS. Mary and Elizabeth Hospital, Louisville, Ky., on February 14, after an illness of one week. In 1926 the governor appointed her a member of the Kentucky State Board of Nurse Examiners for a term of four years.

DR. GEORGE DAVID STEWART, a former president of the American College of Surgeons, and professor of surgery, New York University and Bellevue Hospital Medical College, New York City, died recently. He was in his seventy-first year.

FREDERICK BAUERNSCHMIDT, Baltimore, who gave \$2,600,000 to various hospitals in that city during the past six years, besides distributing hundreds of thousands of dollars in other benefactions, died at his home in that city on March 8. MR. BAUERNSCHMIDT was in his seventieth year.

MOTHER MARY, formerly superintendent, Champlain Valley Hospital, Plattsburg, N. Y., has assumed the superintendency, St. John's Hospital of St. Lawrence County, Ogdensburg, N. Y., succeeding MOTHER JOSEPH, who died recently.

DR. DOUGLAS HUNT STEWART, prominent surgeon, who for approximately twenty years was associated with the Knickerbocker Hospital, New York City, died March 15. DOCTOR STEWART founded, in 1917, the varicose vein clinic at the hospital, which was the first clinic of its kind in New York City, and also the world's largest at the time.

Superintendents in Louisville Form New Organization

The Louisville Council of Hospital Superintendents is the name of a new organization that was formed at a recent meeting of hospital superintendents of Louisville, Ky. The council has been organized in order to provide a means for an exchange of ideas by the various superintendents of the city on hospital problems.

The initial meeting was well attended and those present were of the opinion that meetings such as are planned by the new organization will be helpful. Agnes O'Roke, superintendent, Kosair Crippled Children Hospital, was appointed chairman, and Adeline M. Hughes, superintendent, Jewish Hospital, was named secretary. No dues will be charged by the organization.

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NEWS OF THE MONTH (Cont'd)

Coming Meetings

- American Association of Hospital Social Workers.**
President, Elizabeth G. Gardiner, University of Minnesota, Minneapolis.
Executive secretary, Helen Beckley, 18 East Division Street, Chicago.
Next meeting, Detroit, June 11-17.
- American College of Surgeons.**
President, Dr. J. Bentley Squier, New York City.
Director general, Dr. Franklin H. Martin, 40 East Erie Street, Chicago.
Next meeting, Chicago, October 9-13.
- American Dietetic Association.**
President, Dr. Kate Daum, University of Iowa Hospital, Iowa City, Iowa.
Business manager, Dorothy I. Lenfest, 185 North Wabash Avenue, Chicago.
Next meeting, Chicago, October 9-12.
- American Hospital Association.**
President, Dr. George F. Stephens, Winnipeg General Hospital, Winnipeg, Man.
Executive secretary, Dr. Bert W. Caldwell, 18 East Division Street, Chicago.
Next meeting, Milwaukee, September 11-15.
- American Medical Association.**
President, Dr. Dean De Witt Lewis, Johns Hopkins Hospital, Baltimore.
Secretary, Dr. Olin West, 535 North Dearborn Street, Chicago.
Next meeting, Milwaukee, June 12-16.
- American Protestant Hospital Association.**
President, Rev. Thomas A. Hyde, Christ Hospital, Jersey City, N. J.
Executive secretary, Dr. Frank C. English, 3233 Griest Avenue, Cincinnati.
Next meeting, Milwaukee, September 8-11.
- Joint meeting, Arkansas, Oklahoma and Tennessee Hospital Associations.**
Next meeting, Hot Springs, Ark., April 25-26.
- Catholic Hospital Association.**
President, Rev. Alphonse M. Schwitalla, St. Louis University, St. Louis.
Executive secretary, M. R. Kneifl, 1402 South Grand Boulevard, St. Louis.
Next meeting, St. Louis, June 12-15.
- Connecticut Hospital Association.**
President, Oliver H. Bartine, Bridgeport Hospital, Bridgeport.
Secretary, Maud E. Traver, New Britain General Hospital, New Britain.
Next meeting, Torrington, May 5.
- Joint meeting, Illinois, Indiana and Wisconsin Hospital Associations.**
Next meeting, Chicago, May 3-5.
- International Hospital Congress.**
Next meeting, Knocke, Belgium, June 28-July 3.
- Iowa Hospital Association.**
President, Clinton F. Smith, Allen Memorial Hospital, Waterloo.
Secretary, E. C. Pohlman, University Hospital, Iowa City.
Next meeting, Marshalltown, April 19-20.
- Kentucky Hospital Association.**
President, Agnes O'Roke, Kosair Crippled Children Hospital, Louisville.
Secretary, Madge Hamnette, Louisville.
Next meeting, Lexington, May 1.
- Midwest Hospital Association.**
President, John R. Smiley, St. Luke's Hospital, Kansas City, Mo.
Secretary, Walter J. Grolton, Missouri-Pacific Hospital, St. Louis.
Next meeting, Kansas City, Mo., May 26-27.
- Minnesota Hospital Association.**
President, James McNee, St. Luke's Hospital, Duluth.
Secretary-Treasurer, A. M. Calvin, Midway and Mounds Park Hospitals, St. Paul.
Next meeting, Minneapolis, May 25-26.
- New Jersey Hospital Association.**
President, Dr. Guy Payne, Essex County Hospital, Cedar Grove.
Executive secretary, Charles F. Dwyer, Newark City Hospital, Newark.
Next meeting, Asbury Park, May 19-20.
- Hospital Association of New York State.**
President, Boris Fingerhood, Israel Zion Hospital, Brooklyn.
Secretary, Julian Funt, Stuyvesant Park East, New York City.
Next meeting, Buffalo, May 19-20.
- Joint meeting, North Carolina, South Carolina and Virginia Hospital Associations.**
Next meeting, Charleston, S. C., April 5-7.
- Northwest Hospital Association.**
President, Dr. J. W. Efaw, Seattle General Hospital, Seattle, Wash.
Secretary-Treasurer, Rev. Axel M. Green, Emanuel Hospital, Portland, Ore.
Next meeting, Spokane, Wash., April 10-13.
- Ohio Hospital Association.**
President, Mary A. Jamieson, Grant Hospital, Columbus.
Secretary, J. R. Mannix, University Hospitals of Cleveland, Cleveland.
Next meeting, Columbus, May 2-4.
- University Hospital Executives Council.**
President, Robert E. Neff, University of Iowa Hospital, Iowa City, Iowa.
Secretary, John C. Dinsmore, University Clinics, Chicago.
Next meeting, Chicago, May 3.

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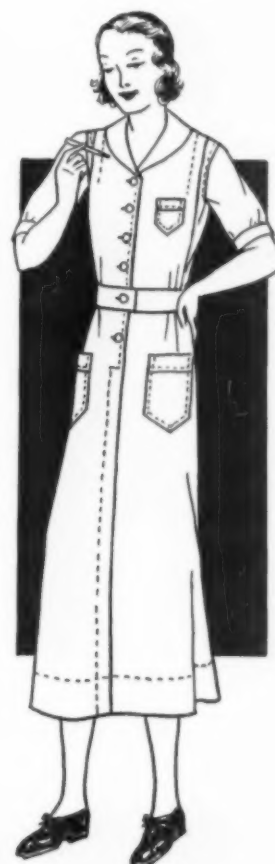
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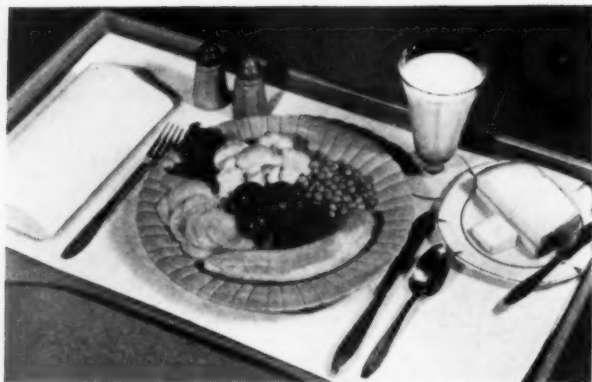
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M. 4. H3





Baked banana is now part of the popular vegetable plate

Bananas BELONG in Hospital Diets

A RECENT writer for a leading hospital publication strongly recommends bananas because they are so agreeable and so well adapted to the digestion of sick people. As a matter of fact, there is scarcely a food on the hospital diet list which, for the money, combines and gives so much in nourishment . . . vitamins . . . minerals.

Bananas have an important place in fruit cups, fruit salads and are delicious and easy to serve as a vegetable—sautéed, broiled or baked.

Sliced bananas will retain their natural color for several hours if they are first kept for half an hour in a heavy, simple syrup (in the ratio of $1\frac{1}{2}$ cups of sugar to 1 cup of water). When used with canned fruits, sliced bananas will not discolor if covered with the syrup from the can. The easiest, most effective way is to place the sliced bananas in the bottom of the container, with the canned fruits on top. Always use a silver or stainless steel knife for slicing . . . Coupon brings recipes for both quantity and individual serving. Send today.



The high food value and easy digestibility of the banana have been recognized by the Committee on Foods of the American Medical Association, and its acceptance seal granted for use in advertising by the United Fruit Company.



Banana orange juice cocktail



Bananas wrapped in bacon, then broiled

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M.H. 4-33

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A. M. A. Council Releases Report on Hospital Service

The March 25 number of the *Journal of the American Medical Association* contains the twelfth annual presentation of hospital data by the Council on Medical Education and Hospitals of the American Medical Association. The data from each hospital are for the last fiscal year preceding the census, and the period covered corresponds generally with the calendar year 1932.

A few of the many interesting facts gleaned from the census are mentioned as follows:

1. This year, for the first time, the total rated capacity of all hospitals exceeds one million. There are 1,014,354 beds.
2. There are 6,562 registered hospitals, as compared with 6,613 for the last previous census.
3. There were 69,199 unoccupied beds in federal, state and local government hospitals and 136,710 in nongovernment hospitals—a total of 205,909 idle beds.
4. The 4,305 general hospitals, on the average, were 63.3 per cent filled. The 776 general hospitals run by government—federal, state and local—were 77.1 per cent occupied, while the 3,529 nongovernment general hospitals were only 55.9 per cent filled. All general hospitals had an average of 145,048 unoccupied beds; nervous and mental hospitals, 24,075, and tuberculosis hospitals, 10,154.
5. The total number of patients admitted to all hospitals in the United States for the fiscal year 1932 was 7,228,151. The average census of all hospitals was 808,445. The general hospitals alone admitted 6,303,573 bed patients during the year.
6. The total number of births in all hospitals was 710,884.
7. Medical care and skill was provided by 113,730 physicians, of whom 101,518 are on attending staffs, 2,018 are resident physicians, 7,757 are interns (including second year interns), and 2,437 are physicians serving as hospital executives.
8. The total patient days in all registered hospitals was 295,082,425, as compared with 283,019,540 for the previous year.

Second Grading of Nursing Schools Is Released

The first installment of the report of the second grading of nursing schools has just recently been sent to the 1,383 hospitals taking part in the survey by the Committee on the Grading of Nursing Schools.

The findings are presented in loose-leaf form, so that early results will not be held up until the entire study is completed. Large colored diagrams are a feature of the reports of the second grading. The loose-leaf arrangement will permit the removal of these diagrams from the cover so that they may be passed from hand to hand at meetings of boards of trustees, nursing school committees and other groups especially concerned with nursing problems.

The text matter has been kept at a minimum, and the diagrams pretty much tell their own story. Each school taking part received four copies of the report, annotated by hand in red ink to show the standing of the particular school on each significant comparison included in the study.

Standards have risen rapidly in the three years that have elapsed since the first and second grading, the committee's figures show. The second grading figures, it is conceded, furnish convincing evidence that, when schools can be helped to study what they are doing and to dis-

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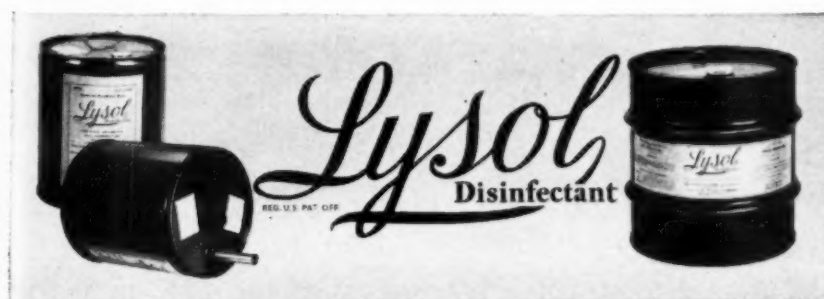
Hospital executives seeking germicidal economy *with* safety, will welcome the new, double-strength "Lysol"—and the new low price. A combination that makes "Lysol's" imitators look more expensive and risky.

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such highly resistant pathogenic organisms as the germs of the typhoid group or the pyogenic cocci (staphylococcus aureus). It contains on an average more germ killing concentrate and less inert ingredients than 10 of its better known substitutes. It destroys germ life even in the presence of large quantities of organic matter. This is in sharp contrast to other preparations, notably chlorine disinfectants which lose 95% or more of their effectiveness under such conditions.

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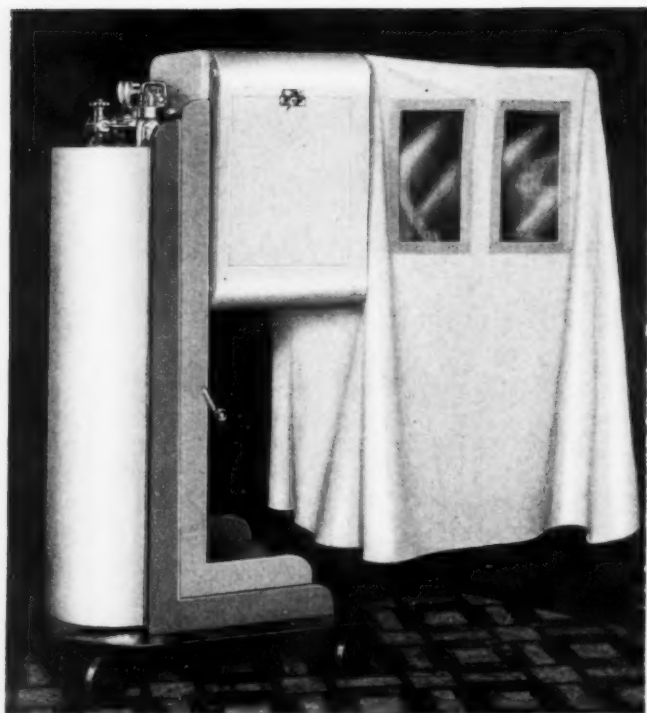
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cover what they ought to be doing, changes will follow all along the line.

"Nursing education is improving and improving rapidly," says Dr. May Ayres Burgess, director of the study. "It is the hope of the grading committee that the reports on the second grading will accelerate that progress.

"There is no school that has received the highest marks in every comparison," Doctor Burgess points out. "Every school is worse than some other school in something, and even schools with enviable reputations have in several instances made records that they will probably regret."

The committee warns the participating schools that, in their zeal to correct the bad, they not forget the good points the survey shows. Another warning concerns the taking of the report as the criticism of the work of any one person. "Nursing education is a problem that concerns everyone connected with running the hospital," the report says. "It is not the sole problem of the superintendent of the hospital or the superintendent of nurses."

The report offers the opportunity to present to the governing groups a brief but constructive program for improvement, it is the belief of the grading committee.

The second grading extended over the first ten months of 1932, a year in which great changes occurred. Many hospitals and many schools of nursing closed during that period. The committee presents the following figures in regard to the number of accredited schools of nursing:

Schools open January 1, 1932, 1,781; new schools accredited by October 15, 1932, 10; total schools open at any time during the year, 1,791; schools closed during the year, 161; schools still open October 15, 1932, 1,630.

Between January 1, 1932, and the time the first grading began in May, 1929, the number of accredited schools of nursing had decreased by 104. But the number of students in these schools had increased during that period by 5,519, the committee's figures show.

Ontario Hospital Employs More Graduate Nurses

In line with its new policy, the Ontario Hospital Training School for Nurses, London, Ont., did not admit a new class of probationers in February. The first probationers to be admitted this year will be the class of next October.

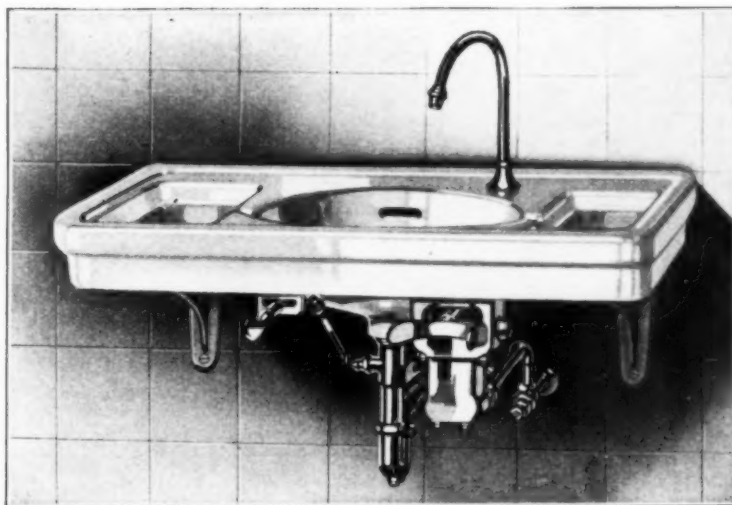
According to Mary L. Jacobs, superintendent of nurses, student nurses are to a certain extent being replaced at the Ontario Hospital by graduates. The staff is maintained at its usual number, graduates doing the work ordinarily done by third-year students. There is no additional cost, according to Miss Jacobs, and the plan is providing employment and maintenance for a number of graduate nurses during a difficult period and lessening to some extent the number of students preparing for graduation.

New Lien Law in Arkansas Benefits Hospitals, Doctors and Nurses

A lien law of benefit to hospitals, nurses and medical practitioners has been passed in Arkansas. The new law includes a claim on all monies coming to patients in case of accidents, and gives the hospital equal rights with the doctor and nurse on such claims.

The legislative committee of the Arkansas Hospital Association worked diligently to secure the passage of the bill, and word has been received from Lee Gammill, superintendent, Baptist State Hospital, Little Rock, that success has crowned the committee's efforts.

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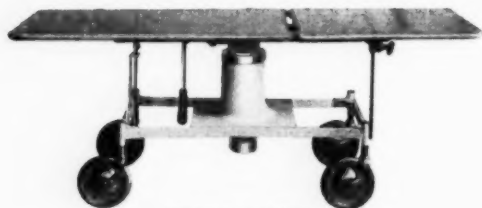
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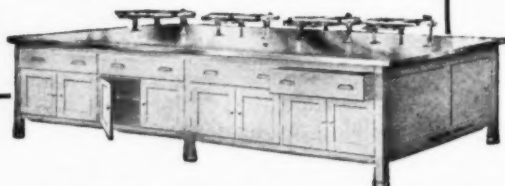
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**Opens Contagious Disease Division
 for Private Patients**

A division for the treatment of private patients with contagious diseases has been opened at the Albert Merritt Billings Hospital, University of Chicago Clinics, Chicago. Ten private rooms in the Billings Hospital are now available for this service, and the number will be increased should the demand warrant this step.

The division is the only one of its kind in the city since the recent closing of the Durand Hospital. While the Chicago Municipal Contagious Disease Hospital and the Cook County Hospital accept indigent patients with contagious diseases, the Durand Hospital, a part of the McCormick Institute for Infectious Diseases, had been the only hospital where private patients with contagious diseases could be isolated. Directors of the institute were forced to close the Durand Hospital because of reduction in income.

**Start Construction of New Naval
 Hospital in Philadelphia**

Construction work was started recently on the large new Naval Hospital, to be erected at Sixteenth Street and Pattison Avenue, Philadelphia. The construction work will cost \$2,587,000. It is estimated that the building will be completed in eighteen months.

According to the plans drawn by Karcher & Smith, architects, the hospital will be a light brick structure, with buff brick trim. The central building will be twelve stories high, flanked by two four-story wings, with a towering pylon on each end. It will accommodate 650 beds, with provisions for 790 in an emergency.

**How to Plan an Employee Manual
 Is Told in Booklet**

To acquaint employees with the ideas, methods and policies of the organization they work for and to give them a complete understanding of the rules and regulations, many organizations have published informative handbooks of varying types. An analysis of the subjects discussed in these manuals, their physical make-up and the methods used to distribute them, is contained in a new report entitled "Employee Handbooks," published by the policyholders service bureau of the Metropolitan Life Insurance Company. The material in the report is based on a review of selected manuals.

That these booklets, when properly planned, have been found to be of distinct value in improving and preserving relations between management and the individual employee, and in increasing efficiency throughout the organization, is one of the facts revealed by the survey. The report observes that the material in these booklets differs to a marked degree. Some of the items that are mentioned in representative handbooks, and which are discussed in the report, include company data, personnel administration, employment, remuneration, hours and attendance, joint relations, health, safety, training and education, economic security, services for employees and general instructions.

Hospital executives interested in this subject may secure copies of "Employee Handbooks" by writing to the policyholders service bureau, Metropolitan Life Insurance Company, 1 Madison Avenue, New York City.



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HOSPITAL EQUIPMENT



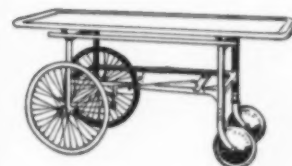
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Send for special catalog of many styles to fit every kind of disability.



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Indispensable for a variety of uses in room service or in dietary.



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Make all Equipment pre-eminently satisfactory. Re-equip your present units with new Colson Casters.

HUNDREDS *Have Accepted* OUR OFFER

Hundreds of skeptical hospital executives wrote in for a set of Shock Absorbing Casters. They expected just "another new caster." With but one exception, all these executives liked these casters so well—they not only bought the trial sets—but ordered thousands of additional sets.

That's why we feel certain you will like them also. You can't realize how superior Shock Absorbing Casters really are—until you see with your own eyes how they cushion equipment and absorb all shocks. Send for your set today, on approval.

Jarvis & Jarvis, Inc.

Manufacturers of Superior
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Representatives in All Principal Cities




SLOAN
FLUSH VALVES
FOR MODERN HOSPITALS

NEWS FROM MANUFACTURERS

A RESILIENT WOOD FIBER FLOORING

A manufactured flooring that is an all wood fiber tile is a recent product of the Masonite Corporation, 111 West Washington Street, Chicago. Masonite Cushioned Flooring is made from wood chips that have been exploded under steam pressure into long fibers. These cellulose fibers are interlaced or felted together into thick mats which are subjected to heat and tremendous pressure to form Presdwood, from which the two outer surfaces of the flooring tile are made. The middle layer of the tile is Quartrboard, which is made by the same process as the Presdwood, but it is pressed to a lesser degree. This gives a resilience to the tile, and hence to the entire floor.

The tiles are made in a variety of sizes, and are dark brown on one surface and a lighter brown on the other. This allows a wide variety of patterns to be obtained in floor layouts.

The flooring is tongued and grooved, and is laid in a



mastic cement over a properly prepared subfloor of either concrete or wood. When the entire floor is laid the tiles are all interlocked as well as cemented to the floor.

The only finishing that is necessary after the floor is laid is damp mopping to remove dust and dirt in preparation for waxing or oiling. The recommended finishes are two applications of regular floor wax, or water emulsion wax, which is less slippery, or an application of a penetrating oil.

Maintenance for this type of floor is the same as that needed for any ordinary waxed or oiled finish, but washing compounds that are alkaline or caustic should not be used. The floor is relatively impervious to acids.

WILL DISTRIBUTE DON BAXTER PRODUCTS

The American Hospital Supply Corporation, 15 North Jefferson Street, Chicago, and 108 Sixth Street, Pittsburgh, will in future act as distributors for Don Baxter Products—dextrose (d-glucose) and physiologic sodium chloride solutions (normal salt) in Vacoliter dispensers. This distribution covers all territory in the United States east of the Rocky Mountains.

The Don Baxter Intravenous Products Corporation will continue to function. Its new address is 15 North Jefferson Street, Chicago.

12½% MONTHLY DIVIDENDS!

That's what a new Vulcan equipment is paying in one typical hotel (name on request)

It took just 8 months to cancel the entire investment. And similar records are being set in many other institutions—clubs, hotels, schools, hospitals, restaurants • No matter what fuel you are using, a new Vulcan gas

installation will cut your cooking costs and pay for itself quickly. It will keep your kitchen cooler. It will make good cooking easier. It will simplify your labor problem.

STANDARD GAS EQUIPMENT CORPORATION, 18 East 41st Street, New York, N. Y., Baltimore, Philadelphia, Aurora, Boston, Chicago, Birmingham. Pacific Coast Distributor: Northwest Gas & Electric Equipment Co., Portland, Ore.



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**VULCAN EQUIPMENT MAKES GAS THE MODERN
EFFICIENCY FUEL . . . CLEAN, FAST, ECONOMICAL**

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Send me full information, showing how Vulcan can cut my cooking costs.

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FINER GLOVES

Made from virgin latex
by the Anode process

A year ago, we sent out this statement to our friends in the hospital field: "First, let us remind you that we sell brown milled gloves of the highest quality. From a purely profit standpoint there is no advantage to us in selling this new Will Ross Surgeons' Glove—an Anode Product. . . But from a service standpoint, from the standpoint of your satisfaction, from the standpoint of economy, knowing the facts about both types of gloves, there is every reason why we should recommend to you that your next order for gloves be for Will Ross Surgeons' Gloves."

A year has passed without a single instance of dissatisfaction. Surgeons are enthusiastic. Reports show as many as fifty autoclavings without apparent deterioration. Thin, sensitive, tough. Undoubtedly the most economical gloves you can buy. So, again we say, try them. R-200 — sizes 6 to 10 inclusive; gross lots, \$3.60 per dozen; smaller quantities, \$4.00 per dozen; single pairs, 40c per pair.

WILL ROSS INC., WHOLESALE HOSPITAL SUPPLIES
779-783 No. Water Street Milwaukee, Wisconsin.

WILL ROSS • latex
SURGEON'S GLOVES

AN AUTOMATIC WATER SOFTENER

The Permutit Company, 440 Fourth Avenue, New York City, has announced a completely automatic industrial zeolite water softener. The softening and the regeneration operations are accomplished by the new controls with a regularity and a precision that eliminates the element of human error.

Precise control of each operation of the softener is secured by a combination of a meter operated switch, electric controls and a motor driven Permutit single valve.

The process is as follows: At the end of the softening run the meter actuates the electric controls, which stop the softening operation. Backwashing then occurs for a regulated period to secure thorough cleansing. A carefully regulated amount of saturated brine is then admitted to assure thorough regeneration without wasting salt. Rinsing with a minimum amount of water follows in order to remove the hardness salts. The softener is again made ready for service by being returned to the control of the meter, which governs the volume of water to be softened and initiates the start of the next regenerating cycle.

The fully automatic type of softener may be had in new models, or the controls may be added to present installations. It is a relatively simple operation to add the automatic feature to existent downflow manual softeners.

DECORATIVE METAL BOOK SHELVING

A new type of metal book shelving that harmonizes with many kinds of interior decoration and is a finished piece of furniture has been developed by Lyon Metal Products, Inc., Aurora, Ill. Beaded uprights are used to cover the joints between the sections, and an end finishing panel is used to give a smooth, continuous surface on the exposed ends of the section group. An ornamental cornice may also be obtained. The steel book shelving is more than a rack for the storage of books, as it adds to the attractive appearance of the library.

All parts of this shelving are interchangeable. The shelves can be quickly adjusted on one-inch centers by raising or lowering four easily removable clips. No tools are necessary, and it is possible to readjust the shelves without removing the books. Additional shelves or sections may be added at any time.

Single face sections for use against the wall or double face sections for use in the center of the room are available. The standard finishes are green and brown. Other finishes such as gray, flat mahogany, flat walnut, two-tone fallow, and cordovan may be had at an additional cost.

A TRIANGULAR SHAPED PILLOW

A pillow that is triangular in shape and offers support for the invalid in various positions from semireclining to upright is being manufactured by the Barcalo Manufacturing Co., Buffalo, N. Y. The sides of the pillow are of three different heights, and three unequal angles, one of which is a right angle. This pillow may be used for children or adults in any one of the six possible positions.

The pillow is filled with kapok, and is covered with a brocaded fabric in green, blue, orchid or rose. The seams are edged in black. A special waterproofed covering is supplied for pillows to be used out of doors.

A loop is provided for carrying the pillow or for hanging it in a storage room, and an ample pocket allows small personal articles to be carried with the pillow. A tape runs lengthwise through the pillow, and may be adjusted to make the pillow harder if desired.

"A hypodermic of pituitary Miss Gray—ARMOUR'S"



"SLIGHT intestinal paresis? See that she gets a hypodermic of pituitary, Miss Gray—Armour's."

The *maximum and unvarying potency* of Armour organotherapeutic preparations is due to the immediate processing of fresh raw material, before the animal heat has left it. Exclusive Armour facilities make this possible. In thirty-five years not one product of the Armour Laboratories has been found wanting in potency. The name *Armour* means reliability. You can specify it with confidence.

When prescribing Surgical Ligatures, Suprarenalin Solution, Concentrated Liver Extract, Concentrated Liver Extract with Iron, always specify ARMOUR'S.



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